RRD BENEFITS
HEALTH | WEALTH | LIFE

2026 COMPARISON CHART

RETIREE GROUP HEALTH PROGRAM

The chart below compares the Retiree Group Health Program and Prescription Drug Program options for 2026. You can verify your eligibility for these options at **rrd.bswift.com** or contact the Benefits Center at **1-877-RRD-4BEN (1-877-773-4236)**, Monday through Friday, 7 a.m. to 7 p.m. CT.

PROGRAM/BENEFIT	AETNA POST-65 RETIREE MEDICARE	BCBSIL PRE-65 RETIREE VALUE		BCBSIL PRE-65 RETIREE PPO	
Medical	**Aetna Member Services** **1-800-307-4830** **AetnaRetireePlans.com**	**BCBSIL Member Services** **1-800-537-9765** **bcbsil.com/rrd**			
		In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Annual Deductible*	$400	$2,000/individual $4,000/family Combined Medical & Pharmacy		$500/individual $1,000/family	$1,000/individual $2,000/family
Annual Out-of-Pocket Maximum*	$2,000/individual	$4,500/individual $9,000/family Combined Medical & Pharmacy		$2,500/individual $5,000/family	$3,000/individual $6,000/family
Coinsurance Percentage	80% or 90%, varies by service	80%	60%	80%	60%
Preventive Care	$0 copay	100% covered with no deductible	60% covered after deductible	100% covered with no deductible	60% covered after deductible
Physician Office Visits	• PCP: $10 copay • Specialist: $20 copay	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Inpatient Hospital Services	$150 copay	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Inpatient/Outpatient Professional Services	80% covered after deductible	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible

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PROGRAM/BENEFIT	AETNA POST-65 RETIREE MEDICARE	BCBSIL PRE-65 RETIREE VALUE		BCBSIL PRE-65 RETIREE PPO	
		In-Network	*Out-of-Network*	*In-Network*	*Out-of-Network*
Outpatient Lab/X-ray	80% covered after deductible	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Outpatient Surgery	90% covered after deductible	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Emergency Room/ Urgent Care Facility	• Emergency Room: $65 copay • Urgent Care Facility: $35 copay	80% covered after deductible	80% covered after deductible, if claims administrator determines true emergency; otherwise, 60% covered after deductible	80% covered after deductible	80% covered after deductible, if claims administrator determines true emergency; otherwise, 60% covered after deductible
Outpatient Rehabilitation Services *Limited to a maximum of 90 visits per year combined with Physical, Occupational, Pulmonary, Cognitive and Speech Therapies*	• PT/OT/ST: 90% covered after deductible • Cardiac/Pulmonary: 90% covered after deductible • Chiropractic: $20 copay	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible
Mental Health and Substance Abuse	• Inpatient: $150 copay • Outpatient: $20 copay	80% covered after deductible	60% covered after deductible	80% covered after deductible	60% covered after deductible

*** Pre-65 Retiree Value option:** If you cover dependents, the Plan starts paying benefits for an individual's claims only after the *total* family deductible has been met, even if those expenses are incurred by only one individual. Similarly, the Plan starts paying 100% only after the *total* family out-of-pocket maximum has been met, even if those expenses are incurred by only one individual.

Charges above usual and customary (U&C) limits are member's responsibility. Amounts above U&C don't count toward the annual deductible or the out-of-pocket maximum.

PROGRAM/BENEFIT	AETNA POST-65 RETIREE MEDICARE		
Prescription Drug	**Aetna 1-800-307-4830 AetnaRetireePlans.com**		
Retail *30-day supply*	***Preferred***	***Standard***	
Tier 1 Generic	Greater of $7 copay or 15% coinsurance	Greater of $10 copay or 20% coinsurance	
Tier 2 Brand formulary	Greater of $10 copay or 25% coinsurance	Greater of $10 copay or 25% coinsurance	
Tier 3 Brand non-formulary	Greater of $10 copay or 50% coinsurance	Greater of $10 copay or 50% coinsurance	
Tier 4 Specialty	Greater of $10 copay or 33% coinsurance	Greater of $10 copay or 33% coinsurance	
Retail or Mail-Order *90-day supply*	***Preferred Retail***	***Preferred Mail***	***Standard Retail or Mail***
Tier 1 Generic	Greater of $21 copay or 15% coinsurance	Greater of $21 copay or 15% coinsurance	Greater of $30 copay or 20% coinsurance
Tier 2 Brand formulary	Greater of $30 copay or 25% coinsurance	Greater of $30 copay or 25% coinsurance	Greater of $30 copay or 25% coinsurance
Tier 3 Brand non-formulary	Greater of $30 copay or 50% coinsurance	Greater of $30 copay or 50% coinsurance	Greater of $30 copay or 50% coinsurance
Tier 4 Specialty	Limited to one-month supply	Limited to one-month supply	Limited to one-month supply
• If you reside in a long-term care facility, your cost share is the same as a 30-day supply at a retail pharmacy and you may receive up to a 31-day supply. • You won't pay more than $35 for a one-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.			
Annual Prescription Drug Out-of-Pocket Maximum	**$2,000 cap on covered Part D drugs** All Medicare plans will include a $2,000 cap on what you pay out-of-pocket for prescription drugs covered by your plan. If your out-of-pocket spending on covered drugs reaches $2,000 (including certain payments made on your behalf, like through the Extra Help program), **you'll automatically get "catastrophic coverage." That means you won't have to pay out-of-pocket for covered Part D drugs** for the rest of the calendar year.		

PROGRAM/BENEFIT	BCBSIL PRE-65 RETIREE VALUE		BCBSIL PRE-65 RETIREE PPO	
Prescription Drug	**CVS Caremark 1-866-273-8402 caremark.com**			
Retail *30-day supply*	***In-Network***	***Out-of-Network***	***In-Network***	***Out-of-Network***
• Tier 1 Generic	80% covered after deductible	60% covered after deductible	80% covered; $10 minimum copay	
• Tier 2 Brand formulary	80% covered after deductible	60% covered after deductible	60% covered; $10 minimum copay	
• Tier 3 Brand non-formulary	80% covered after deductible	60% covered after deductible	50% covered; $10 minimum copay	
Mail-Order *90-day supply*				
• Tier 1 Generic	80% covered after deductible		80% covered; $30 minimum copay	
• Tier 2 Brand formulary	80% covered after deductible		60% covered; $30 minimum copay	
• Tier 3 Brand non-formulary	80% covered after deductible		50% covered; $30 minimum copay	