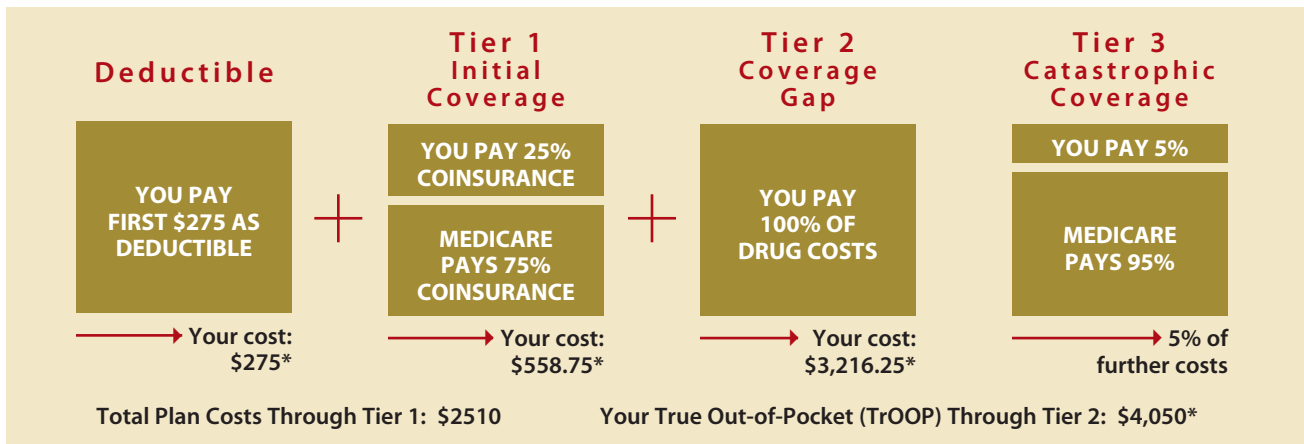


Emeriti offers three Medicare-approved Part D prescription drug options. Rx Plan 3, Emeriti’s basic plan, is slightly richer than the Medicare Standard Part D design illustrated below. Plan 3 is available as a stand-alone option, as well as combined with any of the medical coverages. Rx Plans 1 and 2 are both enhanced plans, which means that they provide coverage in the gap; they also have open formularies (see below). Plans 2 and 3 are available only in combination with one of the Emeriti medical plans.

To select the prescription drug plan that is right for you, you need to understand how Medicare Part D works. The Standard plan design includes several tiers of cost-sharing by the individual and the plan. Take a look at the diagram below. You will pay a monthly premium for the coverage. Then as you begin to incur drug expenses, you pay the full cost of the covered drugs until you reach the annual deductible. Once you have satisfied the deductible, you pay a specified amount of coinsurance for each prescription until you reach the initial coverage limit for Tier 1 of \$2510 in 2008. At that point, if you have additional prescription drug costs for the year, you have reached the Tier 2 coverage gap (or “donut hole”), and you pay 100% of the costs, until your True Out-Of-Pocket (called TrOOP) expenses (the amounts paid by you to satisfy the deductible and in Tiers 1 and 2), reach \$4050 in 2008. If your prescription drug expenses exceed \$4050, you enter Tier 3, where the plan provides catastrophic benefits of 95% and you pay the greater of 5%, or \$2.25 for generic/\$5.60 for brand drugs, for your prescription drug expenses for the rest of the calendar year.



NOTE: Standard Part D also has an annual premium.

Understanding Formularies

An open formulary means that all of the drugs on the formulary are covered, although the plan pays a varying share of the costs for generic drugs, preferred brand drugs and non-preferred brand drugs.

A closed formulary requires you to use only those medications that are designated as covered under the insurer’s preferred drug list. If your brand drug is not covered on the closed formulary, you can speak to your doctor about switching to a drug that is on the preferred drug list. Or your doctor may obtain a medical exception from the insurer for the drug to be covered. If you decide to continue taking medications not covered on the closed formulary without obtaining a medical exception, you will pay the full cost; and these expenses do not count toward the plan’s deductible or out-of-pocket limits.

Both open and closed formularies generally have higher cost-sharing for brand drugs than for generic drugs. All formularies are not alike. Each insurer constructs its own Medicare-approved formulary.

MEDICARE APPROVED, PART D BENEFITS

Rx PLAN BENEFITS	Rx PLAN 1	Rx PLAN 2	Rx PLAN 3
FORMULARY*	OPEN	OPEN	CLOSED
ANNUAL DEDUCTIBLE	\$100	\$275	\$275
INITIAL COINSURANCE (TIER 1)	15% - 30% - 40%**	15% - 30% - 50%**	15% - 30%**
MAIL ORDER DELIVERY (TIER 1)	10% - 25% - 35%**	10% - 25% - 45%**	10% - 25%**
TOTAL COST PAID BY PARTICIPANT AND PLAN (through TIER 1)	\$2510	\$2510	\$2510
SECONDARY COINSURANCE IN COVERAGE GAP (TIER 2)	15% - 30% - 40%**	15% - 30% - 50%**	YOU PAY 100%
MAIL ORDER DELIVERY (TIER 2)	10% - 25% - 35%**	10% - 25% - 45%**	YOU PAY 100%
TRUE OUT-OF-POCKET (Troop) EXPENSES PAID BY PARTICIPANT (DEDUCTIBLE + TIER 1 + TIER 2)	\$4050	\$4050	\$4050
CATASTROPHIC COVERAGE (TIER 3)	YOU PAY \$0	YOU PAY greater of 5% or \$2.25 generic/ \$5.60 brand drugs	YOU PAY greater of 5% or \$2.25 generic/ \$5.60 brand drugs
STEP THERAPY***	Excluded	Included	Included

NOTE: You can choose Rx Plan 3 as a stand-alone option with no medical coverage.

* For retirees participating in Medicare, a formulary is a catalog of prescription medications, approved by Medicare and offered by the insurer. (see section on left for definitions of open and closed formularies).

** Refers to coinsurance for generic/preferred brand/non-preferred brand drugs for Plans 1 and 2, and generic/brand drugs for Plan 3.

*** Step Therapy is a process where in certain cases one or more clinically equivalent drugs must be tried before the prescribed drug is approved. Complying with Step Therapy can lower out-of-pocket costs by utilizing generic or preferred brand alternatives.

Exclusions and limitations for the Prescription Drug Plans (PDP):

Please refer to the plan documents (Evidence of Coverage) for a complete listing of benefits, exclusions and limitations. The following is a listing of excluded Medicare (Part D) prescription drugs:

- Drugs used for weight loss, gain or anorexia
- Cosmetic drugs
- Prescription vitamins and minerals, except prenatal vitamins and fluoride
- Barbiturates
- Outpatient drugs that the manufacturer requires testing/monitoring for, and limits that testing or obtaining the drug to itself or a designee
- Drugs covered under Part B
- Drugs used to promote fertility
- Drugs used for symptomatic relief of cough and colds
- Non-prescription drugs (OTC)
- Benzodiazepines
- Erectile Dysfunction drugs

Benefits coverage is provided by Aetna Life Insurance Company, a Medicare Prescription Drug Plan sponsor with a Medicare contract and benefits, limitations, service areas and premiums are subject to change on January 1 of each year.

This material is for informational purposes only. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Aetna does not provide care or guarantee access to health services. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. While this material is believed to be accurate as of the print date, it is subject to change.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. However, they help control the overall costs of prescription drug coverage.

Enrollees must use network pharmacies to receive plan benefits except under emergency circumstances. Covered Part D drugs are available at out-of-network pharmacies in special circumstances, including illness while traveling within the United States but outside of the plan's service area where there is no network pharmacy. An additional cost may be incurred for drugs received at an out-of-network pharmacy.

You must be entitled to Medicare Part A or Part B and continue to pay your Part B premium, if not otherwise paid for under Medicaid or by another third-party. You may only be enrolled in one Medicare Prescription Drug plan at a time.

If you are enrolled in a Medicare Advantage (MA) Plan, you may not enroll in a Medicare Prescription Drug Plan, unless you are a member of a Private Fee-for-Service MA Plan (PFFS), a Medical Savings Account MA Plan (MSA), or an 1876 Cost Plan.

If an individual qualifies for extra help with the Medicare prescription drug plan costs, premium and costs at the pharmacy may be lower. Upon enrollment in the Aetna Medicare plan, Medicare will tell us how much extra help an individual is getting. An individual can obtain information on whether they qualify by calling 1-800-Medicare (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.