

MEDICAL PLAN FEATURES	Medicare Supplement PLAN 1	Medicare Supplement PLAN 2	Private Fee-for-Service (PFFS) PLAN 1	Private Fee-for-Service (PFFS) PLAN 2
MEDICAL Emeriti Annual Medical Deductible <i>Medicare Parts A & B deductibles (payable under the Medicare Supplement plans only) and coinsurance count toward this deductible</i>	\$200	\$750	\$300	\$500
Participant Coinsurance <i>(Aetna pays balance)</i>	20%	20%	15%	20%
Emeriti Annual Maximum Out-of-Pocket includes any Medicare deductibles (paid under the Medicare Supplement plans only) and coinsurance, Emeriti deductibles and coinsurance	\$1250	\$2000	\$2750	\$3500
Lifetime Maximum	unlimited	unlimited	unlimited	unlimited
HOSPITAL SERVICES <i>(Building on Medicare Part A)</i> Hospital Stays <i>(based on a benefit period)***</i>	Days 1-60: Medicare pays all but \$1024 hospital deductible. YOU PAY 20% of \$1024.* Days 61-90: Medicare pays all but \$256 per day. YOU PAY 20% of \$256.* Days 91-150: Medicare pays all but \$512 per day. YOU PAY 20% of \$512.* Beyond 150 days: there are 60 lifetime reserve days where Medicare pays all but \$512 in 2008. YOU PAY 20% of \$512.* Beyond those limits: YOU PAY 20% of total costs.*		YOU PAY 15%**	YOU PAY 20%**
Skilled Nursing Facility Stay <i>(certain requirements apply) (based on a benefit period)***</i>	Days 1-20: YOU PAY \$0. Days 21-100: Medicare pays all but \$128 per day.* YOU PAY 20% of \$128 per day. Beyond 100 days: YOU PAY 20% of total.*		Days 1-20: YOU PAY 0%. Days 20-100: YOU PAY 15%.** (100 days per benefit period.) Beyond 100 days: not covered.	Days 1-20: YOU PAY 0%. Days 20-100: YOU PAY 20%.** (100 days per benefit period.) Beyond 100 days: not covered.

* Under the Medicare Supplement plans, all costs that you pay count toward the Emeriti plan deductible and annual out of pocket maximum. For example, the Medicare Parts A and B deductibles count toward your Emeriti plan deductible and out-of-pocket limit. Your Emeriti coinsurance payments also count towards your Emeriti out-of-pocket limit. When the applicable deductibles have been satisfied, Aetna usually pays 80% of the remaining balance after what Medicare pays. You pay the other 20% of that remaining balance, or 4% of the total Medicare allowable costs. Note, some preventive care is reimbursed at 100% before the Emeriti plan deductible is applied.

** Under the PFFS plans, you do not have a Medicare Part A or B deductible, only the Emeriti plan deductible. Aetna is the only Medicare payor. After the Emeriti deductible, Aetna pays either 85% (Plan 1) or 80% (Plan 2) for medically necessary covered expenses allowable under Medicare. You pay the balance, up to the annual out-of-pocket maximum. Note that many preventive care services are reimbursed at 100%, before the Emeriti plan deductible.

***A benefit period lasts from when you go into the hospital or a skilled nursing facility (SNF) until you are released for a period of 60 days in a row. If you are re-hospitalized within that 60 day period, you remain in the same benefit period for purposes of the deductible and the day limits outlined above. If you are hospitalized (or go into an SNF) after the 60 days, you will start a new benefit period. There is no limit to the number of benefit periods you might have in a year.

MEDICAL PLAN FEATURES	Medicare Supplement PLAN 1	Medicare Supplement PLAN 2	Private Fee-for-Service (PFFS) PLAN 1	Private Fee-for-Service (PFFS) PLAN 2
Home Health Care	YOU PAY \$0 for Medicare approved care. For medically necessary care that Medicare does not cover, you pay 20%,* maximum 100 visits (at 4 hours) per calendar year. Medicare pays 80% of approved durable medical equipment. YOU PAY 20% of balance after Medicare.		YOU PAY 0%	YOU PAY 0%
Hospice Care	YOU PAY \$0 if you meet certain Medicare requirements. Beyond what Medicare pays, if approved by Aetna, you pay 20%* up to 30 days inpatient with a \$10,000 outpatient lifetime maximum. Beyond 30 days/\$10,000: not covered.		YOU PAY 0% (covered 100% by Medicare at Medicare certified hospice).	YOU PAY 0% (covered 100% by Medicare at Medicare certified hospice).
Inpatient Mental Illness	(in general hospital, see Hospital Stay on previous page) Psychiatric hospitals: days 1-190 lifetime, YOU PAY \$0. Beyond 190 days: YOU PAY 20%.*		Days 1-190 lifetime: YOU PAY 15%. After 190 days lifetime: not covered.	Days 1-190 lifetime: YOU PAY 0%. After 190 days lifetime: not covered.
Inpatient Substance Abuse	(same as Inpatient Mental Illness)		(same as Inpatient Mental Illness)	(same as Inpatient Mental Illness)
PHYSICIAN/DIAGNOSTIC SERVICES <i>(Building on Medicare Part B)</i>				
Medicare Part B Annual Deductible	\$135* (this counts toward satisfying your Emeriti deductible and your out-of-pocket limit).		YOU PAY \$0	YOU PAY \$0
Preventive Care Services	YOU PAY \$0, deductible waived, \$300 preventive care allowance annually, after anything that Medicare pays.		Deductible waived on all preventive care.	Deductible waived on all preventive care.
Routine Physical Exams/ Immunizations	<i>Tetanus-diphtheria booster (every 10 years); annual influenza vaccine; Pneumovax; Pnu-immune (once); Varicella vaccine (2 doses 4-8 wks apart if no history of chickenpox; high-risk immunizations; Hepatitis B (3 doses if high risk); Meningitis vaccine; Hepatitis A</i>		YOU PAY 0%	YOU PAY 0%
Routine Eye Exam	YOU PAY \$0, deductible waived, up to \$100 allowance every 24 months.		YOU PAY 0%	YOU PAY 0%
Routine Hearing Screening	YOU PAY \$0, deductible waived, up to \$100 allowance every 24 months.		YOU PAY 0%	YOU PAY 0%
Hearing Aid Reimbursement	Discounts available.		Aetna reimburses up to \$500 every 36 mos. Discounts available thereafter.	Aetna reimburses up to \$500 every 36 mos. Discounts available thereafter.
Routine Gynecological Exams <i>(1 per calendar year, including 1 pap smear and related fees)</i>	YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 0%	YOU PAY 0%

MEDICAL PLAN FEATURES	Medicare Supplement PLAN 1	Medicare Supplement PLAN 2	Private Fee-for-Service (PFFS) PLAN 1	Private Fee-for-Service (PFFS) PLAN 2
Annual Routine Mammograms	YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 0%	YOU PAY 0%
Routine Annual Digital Rectal Exams (DRE)/Prostate Specific Antigen Test	YOU PAY 20% of the balance after Medicare pays for the DRE and Prostate Specific Antigen Test. YOU PAY \$0 for PSA Test.		YOU PAY 0%	YOU PAY 0%
Colorectal Cancer Screening	YOU PAY 20% of the balance after Medicare pays.* <i>Flex sigmoid/double barium enema (1 every 5 years); Colonoscopy (1 every 10 years); CA 125 test post treatment for ovarian cancer.</i>		YOU PAY 0%	YOU PAY 0%
Bone Density Test	Medicare pays 80%, YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 0%	YOU PAY 0%
Allergy Testing/Treatment	Medicare pays 80%, YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Diabetic Supplies	Medicare pays 80% for some supplies, subject to certain Medicare rules. YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 0%	YOU PAY 0%
Physician and Specialist Office Visits and Services	Medicare pays 80%, YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Outpatient Surgery and Services	Medicare pays 80%, YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Physician In-Hospital Services	Medicare pays 80%, YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Diagnostic Procedures (Lab and X-Ray)	YOU PAY \$0 for Medicare-covered lab services. For covered diagnostic tests and X-rays, YOU PAY 20% of the balance after Medicare pays.		YOU PAY 15%**	YOU PAY 20%**
Ambulance	Medicare pays 80% of Medicare-approved amount. YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Urgent Care Provider	Medicare pays 80%, YOU PAY 20% of the balance after Medicare pays.*		\$35 copay	\$35 copay
Emergency Room	Medicare pays all but a co-payment for hospital services (waived if admitted) and pays 80% for physician services. YOU PAY 20% of the balance after Medicare pays* (waived if admitted).		\$50 copay (waived if admitted)	\$50 copay (waived if admitted)
Outpatient Dialysis/Chemotherapy/Radiation	Medicare generally pays 80% (all but a co-payment for radiation treatment in a hospital). YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**

MEDICAL PLAN FEATURES	Medicare Supplement PLAN 1	Medicare Supplement PLAN 2	Private Fee-for-Service (PFFS) PLAN 1	Private Fee-for-Service (PFFS) PLAN 2
Chiropractic Care	Medicare pays 80% for manual manipulation of the spine. YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15% for manual manipulation of the spine to extent covered by Medicare.**	YOU PAY 20% for manual manipulation of the spine to extent covered by Medicare.**
Podiatry (medically necessary care only)	Medicare pays 80%, YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Outpatient Short-Term Therapy (speech, physical, cardiac, occupational)	Medicare pays 80% for some therapy. YOU PAY 20% of the balance after Medicare pays.* (60 visit maximum per calendar year).		YOU PAY 15%**	YOU PAY 20%**
Outpatient Mental Illness Treatment	Medicare usually pays 50%. YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Outpatient Substance Abuse Treatment	Medicare usually pays 50%. YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Durable Medical Equipment/Prostheses	Medicare covers some prescribed equipment, at varying amounts. YOU PAY 20% of the balance after Medicare pays.*		YOU PAY 15%**	YOU PAY 20%**
Private Duty Nursing (outpatient)	Medicare does not cover this. For medically-necessary treatment, Aetna will pay 80%. YOU PAY 20%* (70 eight-hour shifts maximum per calendar year).		not covered	not covered

NOTE: A Medicare Advantage Private Fee-for-Service plan works differently from a Medicare Supplement plan. Your doctor or hospital must agree to accept the terms and conditions prior to providing health care services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept Aetna's terms and conditions, they may not provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on the Aetna.com website.

Exclusions and Limitations for the Medicare Supplement Plans:

This Medicare Supplement product does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). Depending on the plan selected, new prescription drugs not yet reviewed by Aetna's medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.

Exclusions and limitations for the PFFS Plans:

Please refer to the plan documents (Evidence of Coverage) for a complete listing of benefits, exclusions and limitations. The following is a partial listing of exclusions and limitations under the Aetna Medicare Open Plan (the PFFS plans in the Emeriti Program):

- Services that are not medically necessary nor covered under the Original Medicare Program unless otherwise noted
- Plastic or cosmetic surgery unless medically necessary
- Custodial care
- Experimental procedures or treatments beyond Original Medicare limits
- Routine foot care that is not medically necessary
- Outpatient Prescription Drugs except those covered under Medicare Part B

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. Discount Programs provide access to discounted prices and are not insured benefits. While this material is believed to be accurate as of the print date, it is subject to change.

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

You can receive covered services from any licensed doctor or hospital that is eligible to receive payment from Medicare, agrees to treat you and accepts the Aetna Medicare Open Plan private fee-for-service terms and conditions of payment. The PFFS product does not require a contracted network. You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept Aetna's payment terms and conditions, they may not provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on Aetna's website at: www.aetna.com.