

Emeriti Health Insurance Plan Options

2010 MEDICAL AND RX COMPARISON CHART

Underwritten by Aetna Life Insurance Company

The Emeriti Program enables you to create your own insurance plan from a menu of options. This brochure compares the benefit provisions of each of the medical and Rx options, so that you can select the plan that best meets your needs. You will find information about the dental plan on a separate sheet in this package.

Emeriti offers three different types of plans. Aetna Traditional Choice and PFFS Medical are available nationwide. The new supplemental medical plans are available only in certain states for 2010. (See Note on page 2.) We expect to make these plans more widely available in 2011.

How each Medical plan type works with Medicare

Aetna Traditional Choice is a very rich plan that *coordinates* benefits with Medicare in a very generous fashion. After you have satisfied the \$200 Plan deductible, most claims for Medicare allowable charges will be paid in full. This means that in most situations, the premium and deductible will be your only expenditures. Your Medicare Parts A and B deductibles are satisfied by paying the Emeriti Plan deductible. There are some Plan expenses where the Plan offers extra benefits and Medicare pays nothing; in these situations, you will pay 20% until you reach a maximum out-of-pocket expenditure of \$1250 for the calendar year, including the Plan deductible. (For more information about how this Plan works, see footnote on pages 2 - 3.)

PFFS Medical Plan is a Medicare Part C Plan, where Aetna *provides* all of the benefits of Original Medicare Parts A and B. For most services, you pay the Plan deductible of \$300, but no Medicare Parts A or B deductibles. You do need to pay the Medicare Part B premium. Then you pay 15% coinsurance for your covered expenses, up to a maximum out-of-pocket expenditure of \$2750 for the calendar year, which includes the Emeriti Plan deductible. This Plan also provides extensive preventive services for which you pay nothing. The premiums for this Plan vary considerably from one geographic area to another based on the subsidies that Medicare provides. Providers must accept PFFS plan terms and conditions.

Aetna Supplemental Retiree Medical Plans K and L* *supplement* what Medicare provides. They generally take into account what Medicare pays, subtract that amount, and pay benefits in accordance with the Plan design on the remaining expense. These plans have no plan deductible, but they do have coinsurance. You pay a portion of the Medicare Part A deductible and 100% of the Part B deductible. After you reach the annual out-of-pocket maximum, the plan pays 100%.

*In New York the names of these group health products are the Aetna Retiree Medical Plans 5 and 6, and in all other states, Aetna Supplemental Retiree Medical Plans K and L.

CHOOSE YOUR MEDICAL COVERAGE FOR 2010

Medical Plan Features	Original Medicare Pays	Aetna Traditional Choice Plan ¹	Aetna Supplemental Retiree Medical Plan L ²	Aetna Supplemental Retiree Medical Plan K ²	PFFS Medical Plan (Private Fee-for-Service)
Plan Deductible	n/a	You pay \$200	none	none	\$300 (you don't pay Medicare Parts A & B deductibles)
Coinsurance	Generally Medicare pays 80%/ retiree pays 20% after applicable Part A or B deductible has been satisfied, or in accordance with specific benefits.	You pay 20%; once the Plan coordinates payment with Medicare, your out-of-pocket costs are limited. (See footnote ¹ below).	You pay 25% of the balance after Medicare payment	You pay 50% of the balance after Medicare payment	You pay 15%
Emeriti Annual Out-of-Pocket Maximum	n/a	You pay a maximum of \$1250 per calendar year. Includes Emeriti Plan deductible and coinsurance	You pay a maximum of \$2310 per calendar year. Includes Medicare deductibles/ coinsurance and Emeriti Plan coinsurance	You pay a maximum of \$4620 per calendar year. Includes Medicare deductibles/ coinsurance and Emeriti Plan coinsurance	You pay a maximum of \$2750 per calendar year. Includes Emeriti Plan deductibles and coinsurance
Lifetime Maximum	n/a	unlimited	unlimited	unlimited	unlimited
Preventive Services Covered by Medicare⁴	Payments vary. Member may pay nothing. Some benefits subject to 20% coinsurance or \$155 yearly Part B deductible	You generally pay nothing ¹	You pay nothing	You pay nothing	Plan deductible waived on all preventive care. You pay nothing
Preventive Services Not Covered by Medicare	n/a	Plan deductible waived for specified services. ⁵ You pay nothing within allowable amounts.	No coverage	No coverage	Plan deductible waived on all preventive care. You pay nothing
Part A - Hospital Care Days 1-60	All except the \$1,100 Medicare Part A deductible each benefit period³	You generally pay nothing ¹	You pay 25% of \$1,100 Medicare Part A deductible each benefit period ³	You pay 50% of \$1,100 Medicare Part A deductible each benefit period ³	You pay 15%. No Medicare Part A deductible.
Days 61-90	All except \$275 per day each benefit period ³	You generally pay nothing ¹	You pay nothing	You pay nothing	You pay 15%
Days 91-150	All except \$550 per "lifetime reserve day" (up to 60 days lifetime)	You generally pay nothing ¹	You pay nothing	You pay nothing	You pay 15%
After lifetime reserve days exhausted:	You pay 100%	You generally pay nothing ¹	You pay nothing for additional 365 days	You pay nothing for additional 365 days	You pay 15%
Inpatient Psychiatric	Limited to 190 days (lifetime) in psychiatric hospital	You generally pay nothing ¹	Medicare covers 190 day lifetime in psychiatric hospital. Then no coverage	Medicare covers 190 day lifetime in psychiatric hospital. Then no coverage	You pay 15%. Unlimited days.

¹Traditional Choice Medical Plan is an indemnity plan that coordinates with Medicare and pays secondary to Medicare. Here is how coordination of benefits works between the Traditional Choice Medical Plan and Medicare. Aetna will calculate the payments under the Plan, which has a \$200 deductible and 20% coinsurance, without considering Medicare. Aetna will then calculate what Medicare will pay. Aetna will pay either what the Plan would pay if it were the only payor, or the amount that when added to what Medicare pays equals 100% of plan expenses, whichever is less. ("Plan Expenses" means any necessary and reasonable health expenses, part or all of which is covered under this Plan.) This means that after you have paid the \$200 deductible and perhaps a limited amount of coinsurance, you will generally pay nothing. This is likely to happen before you reach the Plan out-of-pocket calendar year maximum of \$1250.

²In New York the names of these group health products are the Aetna Retiree Medical Plans 5 and 6, and in all other states, Aetna Supplemental Retiree Medical Plans K and L.

³A benefit period lasts from admittance to a hospital or Skilled Nursing Facility (SNF) until 60 days after release. Re-admission within that 60 day period is part of the same benefit period for purposes of the deductible and day limits. Hospitalizations or admissions to a SNF after the 60 days start a new benefit period, with a new deductible and new day limits. There is no limit to the number of benefit periods in a year.

⁴Includes routine annual (calendar year): gynecological exams and pap smear, mammograms, PSA/DRE tests. Also routine colonoscopy (one every 10 years); routine sigmoidoscopy (one every five years); bone density test (one every 2 years); other screenings for those at high risk. Not all services are covered every year. Medicare determines frequency and payment.

⁵Annual physical: \$300 allowance (tetanus-diphtheria booster- every 10 yrs; annual flu vaccine; pneumovax; pnuimmune -once; varicella vaccine-2 doses 4-8 weeks apart if no history of chickenpox; high risk immunizations; hepatitis B-3 doses if high risk; meningitis vaccine; Hepatitis A. Routine eye exams: up to \$100 allowance every 24 months. Routine hearing screening: up to \$100 allowance every 24 months.

NOTE: In most states, the Aetna Supplemental Retiree Medical Plan ("Plan") was filed as a commercial group health product, and, therefore, in these states the Plan is not a Medicare Supplement or Medigap insurance plan. Some of these states may require that this Plan include state mandated benefits. At this time, the Plan is not approved in any state to be offered as a true group Medigap plan. This Plan can only be offered where filed and approved, and the state filing process is complicated, and may be lengthy. **For 2010, the Aetna Supplemental Retiree Medical Plans K and L will be available only to residents in the following states: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Indiana, Iowa, Louisiana, Michigan, Missouri, Mississippi, Nebraska, New Mexico, New York, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, and Wyoming.**

CHOOSE YOUR MEDICAL COVERAGE FOR 2010

Medical Plan Features	Original Medicare Pays	Aetna Traditional Choice Plan ¹	Aetna Supplemental Retiree Medical Plan L ²	Aetna Supplemental Retiree Medical Plan K ²	Private Fee-for-Service (PFFS)
Skilled Nursing Facility Days 1-20	100% each benefit period ³	Covered by Medicare	Covered by Medicare	Covered by Medicare	You pay nothing
Days 21-100	All except \$137.50 per day each benefit period ³	You generally pay nothing, ¹ subject to a 90 day/calendar year maximum for Aetna payments	You pay 25% of \$137.50/day each benefit period ³	You pay 50% of \$137.50/day each benefit period ³	You pay 15%
Days 100 and beyond	Member pays 100%	You pay 20% plus Plan deductible, if not satisfied; subject to a 90 day/calendar year maximum for Aetna payments	No coverage	No coverage	No coverage
Hospice Care	100% for Hospice care. All except \$5 copay/prescription for pain management. All except 5% for inpatient respite care.	You generally pay nothing ¹ except perhaps 20% copay for pain management Rx and 20% of coinsurance for inpatient respite care	You pay nothing except 25% of balance after Medicare payment for pain management Rx inpatient respite care	You pay nothing except 50% of balance after Medicare payment for pain management Rx inpatient respite care	You pay nothing
Physician/Diagnostic/ Outpatient Hospital or Other Provider Services	Member pays \$155 yearly Part B deductible for covered services or items.	You pay no Part B deductible ¹ (satisfied by Emeriti Plan deductible)	You pay \$155 annual Medicare Part B deductible	You pay \$155 annual Medicare Part B deductible	You pay 15% No Part B deductible.
	20% of the Medicare-approved amount for most doctor services, outpatient therapy, and preventive services, 100% for Medicare-approved clinical lab services.	You generally pay nothing ¹	You pay 25% of remaining charges	You pay 50% of remaining charges	You pay 15%
Medicare Part B Excess Charges⁴	Member pays 100%	You pay 20% up to Medicare limiting charge. Then no coverage	No coverage	No coverage	No coverage
Durable Medical Equipment	Member pays 20% of Medicare-approved amount for DME after Part B annual deductible.	You generally pay nothing ¹	You pay 25% of remaining charges after Medicare payment	You pay 50% of remaining charges after Medicare payment	You pay 15%
Foreign Travel Urgent/ Emergency Treatment⁵	Member pays 100%	You pay 20% after Plan deductible, if not already satisfied.	No coverage	No coverage	You pay 15%
Home Health Care	Member pays \$0 for home health services	Covered by Medicare ⁶	Covered by Medicare	Covered by Medicare	You pay nothing
Outpatient Psychiatric/ Substance Abuse Treatment	Member pays 45% for most outpatient mental health/ substance abuse care	You generally pay nothing ¹ after Plan deductible, if not already satisfied	You pay 25% of remaining charges	You pay 50% of remaining charges	You pay 15%

¹Traditional Choice Medical Plan is an indemnity plan that coordinates with Medicare and pays secondary to Medicare. Here is how coordination of benefits between the Traditional Choice Medical Plan and Medicare works. Aetna will calculate the payments under the Plan, which has a \$200 deductible and 20% coinsurance, without considering Medicare. Aetna will then calculate what Medicare will pay. Aetna will pay either what the Plan would pay if it were the only payor, or the amount that when added to what Medicare pays equals 100% of plan expenses, whichever is less. ("Plan Expenses" means any necessary and reasonable health expenses, part or all of which is covered under this Plan.) This means that after you have paid the \$200 deductible and perhaps a limited amount of coinsurance, you will generally pay nothing. This is likely to happen before you reach the Plan out-of-pocket calendar year maximum of \$1250.

²In New York the names of these group health products are the Aetna Retiree Medical Plans 5 and 6, and in all other states, Aetna Supplemental Retiree Medical Plans K and L.

³A benefit period lasts from admittance to a hospital or Skilled Nursing Facility (SNF) until 60 days after release. Re-admission within that 60 day period is part of the same benefit period for purposes of the deductible and day limits. Hospitalizations or admissions to a SNF after the 60 days start a new benefit period, with a new deductible and new day limits. There is no limit to the number of benefit periods in a year.

⁴For those providers who do not accept assignment, limiting charge is difference between Medicare's approved amount and provider's actual charge, up to 15% over Medicare approved amount.

⁵Covers urgent or emergency treatment while traveling outside the U.S. for up to 6 months each year.

⁶Up to 120 visits per calendar year, prior hospital confinement not required.

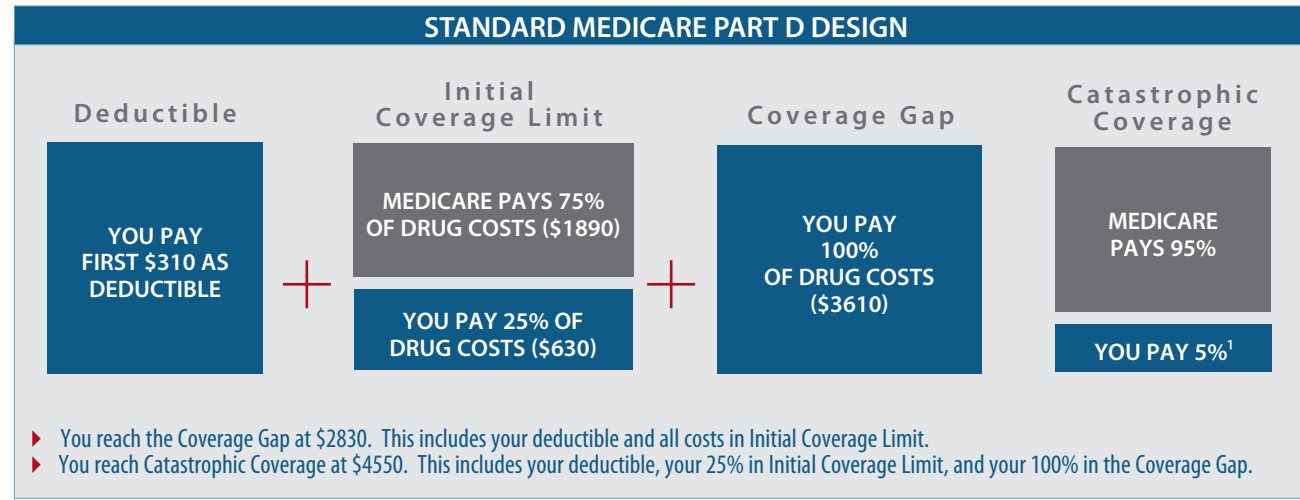
NOTE: In most states, the Aetna Supplemental Retiree Medical Plan ("Plan") was filed as a commercial group health product, and, therefore, in these states the Plan is not a Medicare Supplement or Medigap insurance plan. Some of these states may require that this Plan include state mandated benefits. At this time, the Plan is not approved in any state to be offered as a true group Medigap plan. This Plan can only be offered where filed and approved, and the state filing process is complicated, and may be lengthy. For 2010, the Aetna Supplemental Retiree Medical Plans K and L will be available only to residents in the following states: Alabama, Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Georgia, Indiana, Iowa, Louisiana, Michigan, Missouri, Mississippi, Nebraska, New Mexico, New York, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, and Wyoming.

CHOOSE YOUR PRESCRIPTION DRUG COVERAGE FOR 2010

Emeriti offers three Medicare-approved Part D prescription drug plans¹. The menu of Rx plan choices offers a range of coverages, at different premium levels:

- Options for standard or open formulary
- Broad menu of drugs commonly prescribed for retirees
- Options to help fill the coverage gap (or “donut hole”)
- Flexibility of retail purchase or discount mail order delivery
- Access to more than 90% of U.S. retail pharmacies

To choose the Rx plan that is right for you, you need to understand how Medicare Part D works. The 2010 Standard plan design, as illustrated below, includes several phases of cost-sharing by you and the Plan. First, you pay a monthly premium. Then, as you begin to incur drug expenses, you pay the full cost, up to the annual Deductible amount (\$310). Then, you pay 25% coinsurance (the Plan pays 75%) for each prescription, up to the Initial Coverage Limit (\$2830 in total costs paid by you and the Plan). If you have additional costs in the calendar year, you are in the Coverage Gap, and you pay 100% of the costs, until your True Out-of-Pocket (called TrOOP) expenditures reach \$4550. If your Rx expenditures exceed \$4550, you move to Catastrophic Coverage, where you pay the greater of 5% or \$2.50 for covered generic drugs (including brand drugs treated as generic drugs), and the greater of 5% or \$6.30 for all other drugs, for the remainder of the calendar year.



¹Greater of \$2.50 or 5% for covered generic (including brand drugs treated as generic) drugs. Greater of \$6.30 or 5% for all other drugs.

Understanding Formularies

A formulary is a catalogue of prescription medications, approved by Medicare for Part D plans. Each insurer constructs its own Medicare-approved formulary. **An open formulary** covers all drugs on the Medicare formulary, with the plan paying a varying share of the costs for generic drugs, preferred brand drugs, and non-preferred brand drugs. **A standard 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 standard formulary, you can see if your doctor will prescribe 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 to take a drug not covered on the standard formulary without obtaining a medical exception, you will pay the full cost, and those expenses do not count toward the plan's deductible or out-of-pocket limits.

¹There is a fourth plan which is closed to new entrants. If you are currently in that plan, you can stay in it for 2010. Please call the Emeriti Service Center for a description of its benefits if you have not been sent one.

Emeriti's 2010 Part D Prescription Drug (Rx) Plans

Rx PLAN BENEFITS	Rx HIGH PLAN	Rx MID PLAN	Rx LOW PLAN
Formulary	Open	Open	Standard
Annual Deductible	\$100	\$100	\$310
Initial Coverage Limit Coinsurance¹ (retail)	Initial Coverage Limit Up to \$2,830 in total drug expenditures		
Coinsurance¹ (mail order)	You pay 15% - 30% - 40% You pay 10% - 25% - 35%	You pay 15% - 30% - 50% You pay 10% - 25% - 45%	You pay 15% - 30% You pay 10% - 25%
Coverage Gap After \$2,830 in total drug expenditures (Initial Coverage Limit) but before spending up to \$4,550 out-of-pocket (TrOOP)			
Coverage Gap Coinsurance¹ (retail)	You pay 15% - 30% - 40%	You pay 15% generic drug coverage only	No coverage
Coinsurance¹ (mail order)	You pay 10% - 25% - 35%	You pay 10% generic drug coverage only	
Catastrophic Coverage After reaching \$4,550 out-of-pocket (TrOOP)			
Catastrophic Coverage	You pay \$0	You pay greater of 5% or \$2.50 generic/\$6.30 brand	You pay greater of 5% or \$2.50 generic/\$6.30 brand
Step Therapy²	Not required	Required for some drugs	Required for some drugs
Precertification³	Required for some drugs	Required for some drugs	Required for some drugs

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

¹Refers to coinsurance for generic/preferred brand/non-preferred brand drugs for the Rx High and Mid Plans, and generic/brand drugs for the Rx Low Plan.

²Step Therapy is a process where in certain cases one or more clinically equivalent drugs must be tried before the prescribed drug is approved. Step Therapy can lower out-of-pocket costs by utilizing generic or preferred brand alternatives.

³In all plans, some drugs may require precertification, so that Aetna can talk to the prescribing physician about alternative medications or dosages that might be safer or more appropriate for the patient or condition. Medicare requires Part D plans to develop prudent utilization standards as part of the approved Medicare formulary. Precertification helps to fulfill that requirement.

Exclusions and Limitations for the Aetna Traditional Choice Plan:

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. Product availability may vary by state.

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).

Plans are provided by Aetna Life Insurance Company.

Exclusions and Limitations for the Aetna Supplemental Retiree Medical Plan:

NOTE: IN THE STATE OF NEW YORK THIS GROUP HEALTH PRODUCT IS NAMED THE "AETNA RETIREE MEDICAL PLAN". IN ALL OTHER STATES THIS GROUP HEALTH PRODUCT IS NAMED THE "AETNA SUPPLEMENTAL RETIREE MEDICAL PLAN" (HEREINAFTER COLLECTIVELY REFERRED TO AS "RETIREE MEDICAL PLAN").

Health insurance benefits are underwritten by Aetna Life Insurance Company. The Retiree Medical Plan is offered by Aetna Life Insurance Company.

CHCS Services, Inc. is currently the third party administrator (TPA) for the Retiree Medical Plan. This material is for informational purposes only. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Aetna does not provide care or guarantee access to health services. Some benefits are subject to limitations or visit maximums. Members must use a health care provider that is eligible to receive reimbursement under Medicare in order to receive benefits under this plan, except as otherwise noted in the plan documents.

THE AETNA SUPPLEMENTAL RETIREE MEDICAL PLAN/AETNA RETIREE MEDICAL PLAN IS NOT A MEDICARE SUPPLEMENT INSURANCE PLAN OR MEDIGAP INSURANCE PLAN. This is an employer group retiree medical plan and may provide benefits that are different from a Medicare Supplement plan. You must meet the eligibility criteria established by your former employer, be enrolled in Medicare Parts A & B, and continue to pay Medicare Part A premium (if applicable) and Medicare Part B premium to be eligible to enroll in and remain enrolled in this plan. The Retiree Medical Plan will not provide coverage for services, supplies or treatment that is covered under Original Medicare. The Retiree Medical Plan covers only Medicare-approved charges up to the Medicare allowable amount, unless otherwise noted in the plan documents. Your state may offer you counseling services and advice regarding your health insurance. For more information about Medicare and other insurance, review the "Guide to Health Insurance for People with Medicare" published by the federal government and available at www.medicare.gov.

The Retiree Medical Plan offering is pending state filing and approval in some states. The state product filing process is complicated by the unique variations in state requirements, and some states may have lengthy product approval timelines.

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.

In the event of a conflict or inconsistency between this material and plan documents, the terms of the plan documents shall govern.

While this material is believed to be accurate as of the print date, it is subject to change.

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 health care 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 web site at: www.aetna.com.

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

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.

New prescription drugs not yet reviewed by Aetna's medication review committee are excluded from coverage unless a medical exception is obtained.

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.

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 pre-

- 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

scription 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.

Call the Emeriti Service Center toll free at 1-866-EMERITI (1-866-363-7484)
(Monday through Friday, 8AM to 8PM ET, 5AM to 5PM PT) if you have any questions.

