



PRIVATE FEE-FOR-SERVICE MEDICAL PLAN

2007

Plan Features

You Pay

Prescription Drug Benefits

Annual Deductible Paid by Participant (Stage 1)
 + Initial Coinsurance Paid by Participant (Stage 2)

 = Total Cost Paid by Participant and Plan in Stages 1 & 2
 + Secondary Coinsurance in "the Gap" Paid by Participant (Stage 3)

 = True Out-Of-Pocket Expenses (TrOOP) Paid by Participant
 (Stages 1+2+3) to Reach Catastrophic Threshold
 Then, Catastrophic Coverage Begins
 (Amount Participant Pays When "the Gap" is Met) (Stage 4)

\$265
 \$5 copayment generic drugs on formulary
 \$35 copayment brand drugs on formulary
 25% specialty drugs

 \$2,400
 100%

 \$3,850

 Greater of \$2.15 and 5% for covered generics
 Greater of \$5.35 and 5% for all other covered drugs

Medical Benefits

Preventive Care
 Routine Physical Exams/Immunizations
 Routine Gynecological Care Exams
 Routine Mammograms
 Digital Rectal Exams/Prostate Specific Antigen Test
 Colorectal Cancer Screening
 Bone Density Test
 Routine Eye Exam
 Routine Hearing Screening
 Hearing Aid Reimbursement

 Physician and Specialist Office Visits
 Allergy Testing/Treatment
 Diagnostic Procedures (Diagnostic Laboratory and X-Ray)
 Urgent Care Provider
 Emergency Room;Worldwide (waived if admitted)
 Ambulance
 Inpatient Hospital Coverage
 Outpatient Surgery
 Inpatient Mental Illness

 Outpatient Mental Illness
 Inpatient Substance Abuse (Detoxification & Rehabilitation)
 Outpatient Substance Abuse (Detoxification & Rehabilitation)
 Skilled Nursing Facility
 (100 days per Medicare benefit period; prior authorization required)
 Home Health Care
 Hospice Care
 Outpatient Short-term Therapy (speech, physical, cardiac, occupational)
 Chiropractic Care
 Durable Medical Equipment/Prosthetic Devices
 Podiatry
 Diabetic Supplies
 Outpatient Dialysis/Chemotherapy/Radiation

Covered 100%

 up to \$500 every 36 months

 \$25 copay
 \$25 copay
 \$25 copay
 \$50 copay
 \$50 copay
 \$25 copay
 \$250 copay per stay
 Covered 100%
 \$250 copay; 190 lifetime day limit,
 combined with Inpatient Substance Abuse
 \$25 copay
 \$250 copay; 190 lifetime day limit
 \$25 copay
 \$0 days 1-10; \$25 days 11-20; \$50 days 21-100

 Covered 100%
 Covered by Medicare at a Medicare-certified hospice
 \$25 copay
 \$25 copay
 20% coinsurance
 \$25 copay
 Covered 100%
 \$25 copay

EMERITI PLAN VI: AETNA'S PRIVATE FEE-FOR-SERVICE PLAN

Emeriti is pleased to offer a new nationally-available Medicare Part C insurance option, beginning in 2007. Called a Private Fee-for-Service Plan, this Medicare Advantage plan is an alternative to Original Medicare and the typical HMO arrangement associated with Medicare Part C. In the Private Fee-for-Service Plan, the retiree assigns rights to Medicare Parts A, B, and D coverage to a private insurer, who is required to provide the standard benefits under Medicare, and who may offer additional features. Unlike HMOs, there are no networks, and there is no primary care physician requirement or referrals. The participant can go to any doctor or any medical facility that is eligible to receive payment under Medicare and agrees to the Private Fee-for-Service payment arrangement.

In the Private Fee-for-Service Plan, the individual continues to pay the premium for Part B directly to Medicare, and pays a monthly plan premium to the insurer (Aetna) for comprehensive coverage, including the Part D prescription drug benefit.

Medicare annually determines the fee it will pay to all Private Fee-for-Service insurers on a county-by-county basis, and the rate may vary considerably from one adjacent county to another. The Medicare reimbursement rate also may vary considerably from one year to the next. Generally, the higher the Medicare payment in a particular county, the smaller the premium charged to the individual.


As in Original Medicare, providers and facilities decide whether or not to participate in a Private-Fee-for-Service Plan. Because it is a relatively new type of arrangement, some providers may not be aware of it. Emeriti will have information on its website that you can give directly to your preferred providers, including an informative letter and wallet card. Before you choose this plan option, be sure that your doctor or other health care providers will be willing to participate. Aetna handles all claims reimbursements and allows providers who do not take assignment with Medicare to balance bill the member up to the Medicare-limiting charge of 15% of covered services. This is the same balance billing provision that exists today under Original Medicare fee-for-service.

Following are frequently asked questions about Private-Fee-for-Service Plans. For other questions, call 1-866-EMERITI (1-866-363-7484).

How does a Private Fee-for-Service Plan compare with a Medicare Advantage Health Maintenance Organization (HMO) under Medicare Part C?

In both plans, Medicare contracts with private insurers to provide Original Medicare services. With a Medicare Advantage HMO, you select a primary care physician who oversees your treatment; and, except for emergency situations, you must stay within the network of providers and facilities and receive referrals in order to obtain covered services. Providers participating in the HMO network agree that their fees will not exceed the insurer's established fee structure without prior authorization. Most HMOs are limited to specific geographic areas; if you move out of the area you will need to find other insurance coverage.

A Private-Fee-for-Service Plan has no gatekeeper and no network. Each provider or facility must agree to accept the terms and condition of payment according to Private-Fee-for-Service Plans. It is up to you to make sure that your doctors and facilities are aware that you are enrolled in a Medicare Advantage Private-Fee-for-Service plan so they may review and agree to accept these terms and conditions. Physicians that do not take assignment with Original Medicare may balance bill up to the Medicare-allowable coverage limits (15%). The Private Fee-for-Service Plan is available nationally, which means that wherever you live or relocate you may continue to be part of the plan and you will have open access to any provider who is eligible for Medicare and willing to accept the Private-Fee-for-Service Plan.



How does a Private Fee-for-Service Plan compare in terms of benefits with an indemnity plan that builds on Medicare, like the Emeriti Plans I, II, and III?

Private-Fee-for-Service Plans must offer the same benefits as Original Medicare. With a Private Fee-for-Service Plan, the insured participant has no deductible, but pays a co-payment for each service, and the insurer pays the rest of the cost. A co-payment is required for every doctor's visit, every drug, etc., with no lifetime limit on plan coverage. Generous preventive benefits are included in the plan for \$0 copayment. Part D benefits are also included.

With an indemnity plan, Medicare is involved as the first payor for hospital, physician, and other benefits provided under Original Medicare Part A and Part B. Where Medicare does not pay the entire cost of a covered benefit, the insurer and the insured participant share the remaining cost. With the Emeriti plan options underwritten by Aetna, the participant pays the appropriate initial annual deductible under the plan for medical benefits, and then pays 20% of the balance, with Aetna paying the rest, until the plan reaches the annual out-of-pocket limit. If annual payments by the participant exceed the out-of-pocket catastrophic threshold under the plan, Aetna will pay 100% of the remaining covered expenses for the balance of the calendar year. The insured participant's cost share for Part D prescription drug benefits varies according to the selected standard or enhanced plan design option. The Emeriti plan options include both types. Indemnity plans generally provide limited, if any, preventive care benefits. The Emeriti Plans I, II, and III, provide allowances for annual physicals, and periodic routine eye and hearing exams. For more information on these benefits, see the enclosed Comparison Chart.

The Private Fee-for-Service Plan and the three comprehensive indemnity plans offered by Aetna under the Emeriti Program all include the provision that participants will be covered for emergency or urgent care anywhere in the world for up to six months a year. (Medicare does not normally cover medical expenses incurred outside of the U.S.) Participants will also be able to add dental coverage from Aetna to any of the Emeriti insurance options for an additional premium. (See the attached information sheet for more information.)

What if the premiums for my Fee-for-Service Plan go up next year, or I want to switch to a provider who does not accept Fee-for-Service Plans?

Medicare determines the fee it will pay to insurers on an annual basis. The fee can change significantly, up or down, which will directly affect the premium that Aetna will charge for the coverage for the following year. If you decide for any reason that you no longer want to participate in the Private Fee-for-Service Plan, you can switch to another available Emeriti option for the following calendar year. The open enrollment period will be from around October 15th until December 31st each year, with coverage effective on January 1.

EXCLUSIONS & LIMITATIONS

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

Disclaimers

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 arranges for the provision of healthcare/dental services. However, Aetna itself is not a provider of healthcare/dental services and therefore, cannot guarantee any results or outcomes. Consult the plan documents (Evidence of Coverage) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan. The availability of a plan or program may vary by geographic service area. With the exception of Aetna Rx Home Delivery[®] service, participating providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable law.

Aetna receives rebates from the manufacturers of many drugs, including many that are on the Preferred Drug List. These rebates do not reduce the amount you pay for an individual prescription drug. However, they help control the overall costs of prescription drug coverage. Your pharmacy benefit provides coverage for many drugs that are not on this list. Also, in some cases, if you need to pay a percentage of the cost of the drug or an amount to meet a deductible, or if your benefit is subject to an annual maximum, your costs may be higher for a preferred drug than they would be for a non-preferred drug. You can find out more about the terms and limitations on your plan by reading your plan documents. You can also contact Member Services. The Preferred Drug List is subject to change.

Aetna Rx Home Delivery[®] refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through mail-order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost it pays for the drugs and the costs of its mail-order pharmacy services. For these purposes, Aetna Rx Home Delivery's cost of purchasing drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

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 are subject to change on January 1 of each year.

You must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable. Providers must be licensed and eligible to receive payment under the federal Medicare program.