



International Frequently Asked  
Questions and Answers Guide



# Spectrum

RTI Benefit Options to Meet Your Changing Needs

# 2010

# 2010 International Benefits Open Enrollment Frequently Asked Questions

This document provides an overview of 2010 benefit changes in the RTI International Spectrum Benefits Program. It is not intended to be an exhaustive discussion of the terms and conditions of these benefits, which will be provided in the relevant summary plan descriptions. In cases of plan interpretation, the summary plan descriptions and plan documents will prevail. These changes will be effective January 1, 2010. RTI International reserves the right to amend, modify, or end any of the plans or benefits discussed in this document.

## ***Benefit Changes***

**Q: What are the changes for my benefits for 2010?**

**A:** There are not any plan design changes for your benefits next year.

**Q: Are my benefit premiums changing?**

**A:** Yes. Most of your benefit coverage is offered through insured plans. Your medical, dental, and long-term disability plans are provided by Aetna Global Benefits. Life insurance coverage is provided by MetLife. The flexible spending accounts are administered by Flores and Associates.

Each year at annual open enrollment, RTI reviews the benefit plan costs for the next plan year and determines how premium costs will be adjusted. For most benefits, RTI pays the majority of the premium costs. For the insured benefits that you have, the premium costs are set by the insurance carriers based upon claims experience, utilization, and the size of the RTI enrolled group. When higher costs are charged to the company, then a portion of the cost increase is passed along to employees in the form of a premium increase.

The following is a summary of changes to employee premium costs for 2010:

- Medical: Your premium costs are not increasing and will remain the same as 2009.
- Dental: You will have a slight increase in your premium costs.
- Long-Term Disability (LTD): RTI did receive an increase in the premium costs for the LTD Plan, and we're passing a portion of the premium increase to our staff for 2010.

See the 2010 Spectrum International Benefit Costs booklet for premium costs.

## ***Enrolling in Coverage***

**Q: What are the open enrollment dates for 2010?**

**A:** Open Enrollment begins Monday, November 2, at 8 a.m. EST and ends Sunday, November 15, at midnight. You can enroll at any time during this period, but we encourage you to enroll as early as possible.

**Q: How do I enroll?**

**A:** From StaffNet, log into GEMS and enroll through Self Service—Benefits—Benefits Enrollment. For more details, see the Instructions for Electing Your 2010 Benefits on the Benefits site at <http://staffnet.rti.org/services/benefits>.

**Q: What if I cannot log in to GEMS?**

**A:** Call the IT Help Desk at 1.919.541.6600.

**Q: What if I log into GEMS and do not have the yellow Select button?**

A: Contact HR Help at 1.919.541.1200, 1.800.334.8571 ext. 21200, or [hrhelp@rti.org](mailto:hrhelp@rti.org).

**Q: What happens after I make my benefit elections?**

A: You will receive a confirmation by e-mail. The confirmation will come from HRHelp with the subject line **"2010 Benefits Confirmation (Please Do Not Reply)"**—don't delete it! If you do not receive a confirmation within 2 business days of submitting your selections, contact HR Help at 1.919.541.1200, 1.800.334.8571 ext. 21200, or [hrhelp@rti.org](mailto:hrhelp@rti.org).

**Q: What if I submit my elections and change my mind?**

A: If you would like to make changes to your benefits, go into GEMS and make any changes before open enrollment ends—at midnight, November 15<sup>th</sup> EST.

**Q: What if I do not want to make changes to my current benefit elections?**

A: If you do not enroll for coverage during annual open enrollment, your current benefit elections, except for the Flexible Spending Accounts, will automatically carry over to 2010. Your Flexible Spending Accounts will default to zero if you do not re-enroll. Remember, if you want to make contributions to the Health Care Spending Account and/or the Dependent Care Spending Account in 2010, you must elect this during open enrollment.

Also remember that you can make changes to your benefits **only** during open enrollment or with a qualified life status change. If you have a qualified life status change, you must make changes to your coverage within 30 days of the date of the life status change event. (See the Making Changes section of the 2010 Spectrum International Benefit Options guide for more information on qualified life status changes.)

**Q: Why does RTI limit the opportunities that staff have to make changes?**

A: The limitations are controlled by government regulations for cafeteria benefit plans. The IRS has strict regulations regarding changes to medical, dental, life insurance, and flexible spending account plans that allow payroll deductions on a pre-tax basis. Once you have elected the amount to contribute, you cannot start, change, or end your contributions during the year unless you have a qualifying change in your life status. See "Life Status Changes" in the Making Changes section of the 2010 Spectrum International Benefit Options guide for a complete list.

## ***Other Information***

### **Medical**

**Q: What does my medical plan cover?**

A: The Aetna Global Benefits Medical Plan reimburses reasonable and customary charges for medically necessary care. Aetna can generally determine appropriate charges without significant delays. Expenses that are not covered generally include experimental treatments. Keep in mind there may also be a maximum reimbursement amount or treatment unit for some services. If you have a question about a specific treatment, contact Aetna toll-free at 1.800.231.7729 or collect at 1.813.775.0190.

**Q: How does my coverage work under the Aetna Medical Plan?**

A: Under the Aetna Medical Plan, two types of plan designs are available, based on where you and your family are located. In the U.S., Aetna offers a preferred provider organization (PPO) program, called "Open Choice," for you and your family. If you are on international assignment outside of the U.S., you are offered traditional medical coverage that allows you to see any provider of your choice.

**Coverage in the U.S.**

- The deductible is \$100 per person or \$200 per family for in- and out-of-network services. Once you meet the deductible, the Plan pays 80% and you pay the remaining 20% for services.
- Aetna's Open Choice PPO lets you visit any provider you choose, but you'll typically pay less when you visit doctors or hospitals that are part of the Aetna U.S. network.
- The Plan pays 100% for routine annual check-ups at any provider. Travel immunizations are also paid at 100%.
- You also have a \$1,000 per person or \$2,000 per family out-of-pocket maximum for both in-network and out-of-network services. Your services are paid at 100% for the remainder of the year after you meet the out-of-pocket maximum.
- Your prescription drugs are offered directly through Aetna, with over 59,000 pharmacies in the Aetna network. When you use an in-network pharmacy, you can receive a generic drug for a \$10 copay or a brand-name drug for a \$35 copay. These copays apply for retail or mail-order drugs. You can even receive up to a 365-day supply to take with you on international assignments.
- If you use an out-of-network pharmacy, the Plan pays 80% for a generic or brand-name drug after you meet the annual deductible.

**Coverage Outside of the U.S.**

- The in-network deductible is \$100 per person or \$200 per family for inpatient and outpatient services. Once you meet the deductible, the Plan pays 80% and you pay the remaining 20% for services.
- You also have a \$1,000 per person or \$2,000 per family out-of-pocket maximum. Your services are paid at 100% for the remainder of the year after you meet the out-of-pocket maximum.
- For doctor visits, the Plan pays 80% after you meet your annual deductible.
- If you are outside of the U.S. and need to fill a prescription, the Plan pays 80% of the cost after you meet your annual deductible.

**Q: Will I receive a new ID card?**

**A:** If you were previously enrolled in the medical coverage, you will not receive a new ID card. However, if you are enrolling in the medical plan for the first time, you'll receive a new ID card in January.

- If you enroll in both the medical and dental plans, you will receive two cards: a medical ID card to be used for medical, vision, and prescription drugs, and a separate dental ID card for dental services. Please remember to keep both cards.
- To receive discounts on eye exams, glasses, and other services, present your ID card to your vision providers in the U.S.
- You can have as many ID cards as you like for your enrolled family members. To request additional cards for you or your family, call Aetna Customer Service toll-free at 1.800.231.7729. You can also call Aetna collect at 1.813.775.0190.

**Q: What must I do if I need emergency care on an international assignment?**

**A:** In the case of an emergency, regardless of where you are, you can see any provider of your choice.

**Q: Does my coverage terminate when I return to the U.S. or my home country for vacation or for an extended stay?**

**A:** Your coverage does not terminate. Your coverage always travels with you and your dependents. Employees remain eligible for coverage as long as they will be returning to their international assignment.

**Q: Will I need to file a claim form if I receive services in the United States?**

**A:** For claims in the U.S. at in-network providers, the provider will file a claim for you. At out-of-network providers, the provider may or may not file a claim for you, meaning you may need to file a claim to receive reimbursement.

**Q: How do I file a claim form for services outside of the United States?**

**A:** For claims outside of the U.S., you will likely pay the bill and submit a claim to Aetna for reimbursement. For a hospital stay, you can contact Aetna at 1.800.231.7729 or collect at 1.813.775.0190 to request a direct settlement with the facility. This will allow the provider to bill Aetna so that you will only be asked to pay your portion of the bill.

**Q: What is the deadline for submitting a claim form?**

**A:** You must send your claim forms to Aetna no later than 27 months after the date of service.

**Q: Will I be able to view claims online?**

**A:** Yes. Once you register at [www.aetnavigators.com](http://www.aetnavigators.com), you will have access to all your claim information online. You may view your claims, track the claim history, and print ID cards at this web site. The information on this web site is member-specific protected health information and is password-protected.

**Q: Does Aetna offer mail-order drugs?**

**A:** Yes. Aetna offers mail-order drugs through Aetna Pharmacy Management. The claim form for requesting a mail-order prescription is available from [www.aetnavigators.com](http://www.aetnavigators.com).

**Q: How will I get my prescription filled on January 1?**

**A:** As of 12:01 a.m. on January 1st, any pharmacy or medical claims will be filled by Aetna. If you fill a prescription inside the U.S., you may present your ID card at any U.S. in-network pharmacy (which includes all major chains) and pay a copay for the prescription. You may receive up to a 365-day supply. Outside the U.S., you will need to fill the prescription and then submit a claim form for reimbursement.

**Q: Will I need to get preauthorization for mental health and substance abuse treatment?**

**A:** Yes. Having Aetna's authorization before getting treatment is required for intensive outpatient programs, partial hospitalization programs, psychological testing, neuropsych testing, outpatient electroconvulsive therapy, biofeedback, amytal interview, hypnosis, psychiatric home care service, and outpatient detoxification, which are reimbursed at the plan's outpatient benefit level.

**Q: How does the preauthorization process work for hospital admissions?**

**A:** Aetna does not require preauthorization unless you are using an out-of-network facility inside the U.S. In this case, you will need to call Aetna's member services at 1.800.231.7729 or collect at 1.813.775.0190 to initiate preauthorization. For any care received inside the U.S. at an in-network facility or outside the U.S., there is no need to preauthorize care.

**Q: What happens if my spouse or I have coverage under another group medical or dental plan?**

**A:** If you are enrolled in another group medical or dental plan such as through your spouse's employer and are also enrolled in RTI's medical plan, then the RTI group health plan will pay first as the primary payor. If your spouse is enrolled in his/her employer's medical or dental plan and also has coverage under RTI's plan, then your spouse's employer plan will pay for his/her medical/dental care first, and the RTI medical or dental plan will pay second.

If you and your spouse have other coverage, the RTI medical or dental plan as either the primary or secondary payor will pay up to the RTI plan maximum percentage only. This means that benefits will

not be coordinated between the insurance companies to pay 100% of the cost. With this in mind, you may want to consider whether having a second plan is best for you and your family. For example, if the other plan pays 80%, and RTI's coverage for the same treatment is also 80%, then RTI will not pay the remaining 20%—you must pay this amount.

## Dental

**Q: Are there any changes to the Aetna Dental Plan?**

**A:** There are no plan changes to the Aetna Dental Plan. The Aetna Dental Plan reimburses reasonable and customary expenses for routine dental exams and medically necessary care but not cosmetic work. If you have questions about a specific treatment, contact Aetna Member Services toll-free at 1.800.231.7729 or collect at 1.813.775.0190.

**Q: Will I receive a separate ID card for dental?**

**A:** If you are currently enrolled in the dental coverage, you will not receive a new ID card. However, if you are enrolling in the dental plan for the first time, you'll receive an ID card in January.

## Flexible Spending Accounts (Applies to U.S. Taxpayers)

**Q: Will I be getting a new debit card?**

**A:** If you are enrolling for the first time in the Health Care Spending Account for 2010, you will receive a debit card in late December from Flores & Associates. If you are already enrolled in the Health Care Spending Account in 2009 and re-enroll in it, you will not receive a new debit card. The Flores & Associates benefit card (debit card) functions just like any debit card and works anywhere VISA is accepted. You will not receive a debit card if you enroll in the Dependent Care Spending Account.

**Q: Do I have to submit receipts when I use the debit card?**

**A:** Although it is very convenient to use your debit card to pay for prescriptions and other services, remember to keep your receipts. Flores & Associates may ask you to submit your receipts to substantiate any expenses you are claiming for reimbursement. You may be asked to submit receipts for any copays that do not match RTI's health care plan or over-the-counter payments, in accordance with IRS guidelines. If you're asked to substantiate the expenses and do not submit debit card receipts during the year, you'll be taxed in the following plan year on the any amounts reimbursed in the prior plan year. For example, suppose you use your debit card in 2010 and are asked to send your receipts to Flores for substantiation during the year. If you do not send your receipts by March 31, 2011, you will be subject to taxation in 2011 on any unsubstantiated expenses that were reimbursed on your debit card.

**Q: How do I view my account?**

**A:** To view contributions, reimbursements, claim history, and account balances, log in to [www.flores247.com](http://www.flores247.com) using your participant ID (PID) and your personal identification number (PIN). (You may use your User Name instead of the PID if you choose.) New participants will be assigned a PID and PIN. This information will be mailed before the start of the plan year.

**Q: How do I obtain my participant ID and personal identification number?**

**A:** Your PID and PIN will be mailed to you after you have enrolled in the FSA plan. After one successful log-in, you may create a User Name and PIN that you prefer. Flores can also provide you with your PID and PIN over the phone if you answer several security questions correctly.

**Q: What types of expenses are reimbursable through the flexible spending accounts?**

**A:** For an extensive list of eligible expenses for the medical and dependent care accounts, visit [www.flores247.com](http://www.flores247.com) and view the *Guide to Allowable Expenses* and *Guide to Allowable OTC Expenses* under "Important Documents" on the main page.

**Q: How do I obtain a claim form?**

**A:** You can fill out a Medical or Dependent Care reimbursement form online at [www.flores247.com](http://www.flores247.com) after you have logged in, or you can get the form from the Forms Library on StaffNet.

**Q: How long do I have to submit claims?**

**A:** Expenses for both the Health Care and Dependent Care Spending accounts must be made by December 31 of each year. You must submit claims for both accounts by March 31 of the following year in order to receive reimbursement.

**Q: What happens to my funds if I terminate, retire, or go on leave of absence?**

**A:** Any expenses submitted for reimbursement in either the medical or dependent care accounts must be incurred while you are enrolled in the program. If you stop contributing to the plan for any reason, you may not be eligible to receive reimbursement for services incurred after you terminate, retire, or go on leave of absence.