



Retirees Open Enrollment
Frequently Asked Questions
and Answers Guide



Spectrum

RTI Benefit Options to Meet Your Changing Needs

2010

Retiree Spectrum Benefits Program Frequently Asked Questions and Answers



This guide provides an overview of benefit changes in the 2010 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 guide.

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2010 Open Enrollment Overview

General Questions

Q: What are the open enrollment dates for 2010?

A: Open Enrollment begins on Monday, November 2, and ends on Monday, November 16. You can enroll at any time during this period, but we encourage you to enroll as early as possible.

Retirees and/or spouses who are *65 or older* will return their enrollment forms directly to **NEBCO no later than November 16**. Retirees and dependents who are *under 65* will return their enrollment forms directly to **Flores no later than November 16**.

Q: What are my benefits choices and changes for 2010?

A: As of January 1, 2010, the following applies for your Retiree Healthcare benefits:

Retirees (or Spouses) Under 65

- Retirees under age 65 and their spouses who are covered by an RTI medical plan will continue to have medical and prescription drug coverage with CIGNA.
- Flores & Associates will continue to administer medical and dental premium payments for retirees/dependents under age 65.
- Prescription drugs: there will no longer be a deductible for generic prescriptions purchased at retail pharmacies under the CIGNA Premier or Standard plans. Deductibles will still apply for preferred brand and non-preferred brand drugs.
- Mental health/substance abuse: limitations for inpatient (30 days) and outpatient (30 visits) will be removed under the CIGNA Mental Health/ Substance Abuse benefits. Treatment for mental health/substance abuse will be covered the same as any other illness.

Retirees (or Spouses) 65 and Over

- All Medicare-eligible (age 65 or older) retirees and their spouses who are covered by an RTI medical plan will continue with one of the NEBCO Plans (Premier or Standard). If you are currently covered under the Standard Plan, you will not be permitted to change to the Premier Plan. You can, however, change from Premier to Standard.
- NEBCO will continue to administer medical (including vision) and dental premium payments for retirees/spouses age 65 and older.
- NOTE: You must be enrolled in both Medicare Part A and B. You should contact the Social Security Administration at www.ssa.gov or 1.800.772.1213 approximately 3 months before your retirement date to get information about signing up for Medicare Part A and B.

All Retirees

- Whether you are under or over age 65, your dental coverage will continue to be provided by Ameritas. You will continue to have two plan options: the Standard Dental Plan or the Premier Dental Plan. If you elected the Premier Dental Plan for 2009, you must remain enrolled in that plan for 2010 (there was a 2-year lock-in period that applied to the Premier Plan). The same 2-year lock-in period will apply if you enroll in the Premier Plan for the first time in 2010. This means you'll be locked into the Premier Plan until December 31, 2011.

Q: What happens to my coverage if I am a Medicare-eligible retiree and my spouse or other dependents are under age 65?

A: Your spouse and eligible dependent children can continue their RTI-sponsored group coverage as long as you maintain your retiree coverage (or if you pre-decease your covered dependents). Your under-65 dependents will remain enrolled in a CIGNA medical plan, and you will be enrolled in the NEBCO medical plan. During open enrollment, you or your dependents may make changes to your coverage.

Q: May I add or drop dependents during the annual open enrollment period?

A: Yes, you may add or drop coverage for your eligible dependents during open enrollment. For example, you may add a dependent if he or she meets the Plan's legal definition of an eligible dependent.

You may change plan options only during the open enrollment period, unless your dependent has a change in coverage under another group health plan that affects his or her eligibility for coverage under this Plan. For example, if your spouse loses coverage under another group health plan, you may add him or her to your coverage during the year. Please note that Social Security numbers will now be required for all dependents, according to the Centers for Medicare and Medicaid Services. RTI is now required to provide Social Security numbers to insurance carriers for reporting purposes.

Q: What happens if I decide to cancel my coverage?

A: Once you waive or terminate RTI retiree health coverage, you cannot re-enter the retiree health plan. This means you cannot enroll in the Retiree Medical or Dental plans at a future date. For example, if you were enrolled in the Retiree Medical or Dental Plans and dropped the coverage, you cannot reenroll in the Retiree Medical or Dental Plans.

If you become employed by another company or organization and enroll in its group health coverage, your RTI group coverage ends and cannot be reinstated. Note: The exception to this is employees who are severed from service January 1, 2005, or after and who were between the ages of 50 and 65 at the time of separation and had 10 or more years of credited service before being separated.

Payments

Q: Will NEBCO and Flores send me reminders to pay?

A: Yes, both companies will continue to send invoices each month with all the information needed to make the payment, including the mailing address. If you are 65 or older and your spouse is younger than 65, you will receive separate invoices from both companies. If this is the case, remember that you must send a payment to two different companies each month.

Q: Will NEBCO and Flores allow me to pay for more than one month at a time?

A: Yes, both NEBCO and Flores will accommodate payments for multiple months. For example, if you would like to pay quarterly or annually, you may send in your payment accordingly.

Q: Will NEBCO and Flores offer the option to draft the payment from my bank account?

A: NEBCO offers the option to have payments drafted from your bank account. (Please see instructions on your monthly invoice or contact NEBCO directly for further assistance.) Flores does not currently offer automatic draft. You can however, set up automatic payments through your bank using online banking. (Please contact your bank for specific information if you are interested.)

Q: What happens if I do not pay my medical or dental premiums each month when they are due?

A: It is very important to pay your premiums each month when they are due. If you do not pay your premium within 60 days from the date it is due, your medical and dental coverage will terminate and cannot be reinstated. For example, if you do not pay your January 1, 2010, premium by March 1, 2010, your coverage will terminate.

Medicare-Eligible Retirees and/or Spouses Age 65 and Over

NEBCO Medical Plan

Q: How do my benefits work under the NEBCO plan?

A: NEBCO administers the plan, with other insurance companies working as part of NEBCO. Monumental Life Insurance Company (as a member of the AEGON Company) is insuring the medical plan. United American is insuring the prescription drug plan. You will receive separate ID cards for your medical and prescription coverage.

Q: How do the Premier and Standard Plans compare?

A: See the plan comparison below:

	NEBCO Premier Plan	NEBCO Standard Plan
Annual Deductible	\$250 deductible for Medicare Part B services*	\$500 deductible for Medicare Part B services*
Out-of-Pocket Maximum	\$1,500	\$3,000
Lifetime Maximum	Unlimited	Unlimited

*The \$135 Medicare Part B deductible is included in the \$250 Premier and \$500 Standard deductibles.

Note: A more detailed Medical Plan Benefit Summary will be included in your enrollment package from NEBCO.

Q: How will my drugs be covered?

A: Your prescription drugs will be covered as shown in the chart on the following page:

Prescription Drug Coverage Under the NEBCO Plans

	NEBCO Premier Plan \$25 deductible (applies to retail and mail-order)		NEBCO Standard Plan \$50 deductible (applies to retail and mail-order)	
	Retail (30-day)	Mail-Order (90-day)	Retail (30-day)	Mail-Order (90-day)
Tier 1 Most generics and certain low-cost, brand name drugs	\$10 copay	\$20 copay	\$10 copay	\$20 copay
Tier 2 Preferred brand name and high-cost generics	\$35 copay	\$70 copay	\$50 copay	\$80 copay
Tier 3 Non-preferred brand name drugs	\$70 copay	\$140 copay	\$100 copay	\$160 copay
Tier 4 Specialty drugs	\$70 copay	\$140 copay	\$100 copay	\$160 copay

NOTE: 90-day retail copay will be three times the 30-day retail copay.

Q: How do I fill my prescription?

A: Present your United American prescription drug ID card and your prescription at any of the 56,000 participating pharmacies in the United American prescription drug network. Participating pharmacies include CVS, Rite-Aid, Target, Wal-Mart, and Walgreens. The plan does not cover prescriptions filled at non-participating pharmacies. To find out about other pharmacies that participate, please call NEBCO at 1.800.883.3757.

Q: How does the mail-order program work?

A: You can contact NEBCO to request information about the mail-order program at any time. You can receive up to a 90-day supply delivered to your home. Refills can be ordered by phone.

Q: Who should I call if I have questions about my medical or prescription drug coverage?

A: If you have any questions about your medical or prescription drug coverage, call NEBCO Customer Care at 1.888.883.3757. You can speak to a customer care representative Monday through Friday, 8:00 a.m. to 8:00 p.m. (Eastern Standard Time).

Q: Will I have one ID card for both medical and prescription drugs?

A: No. You will have a medical card from Monumental Life and a prescription card from United America (labeled “UA Medicare”). Please hold on to both cards and carry them with you. Please note that a card is not required for the vision coverage.

Q: Will I receive new ID cards for 2010?

A: You will only receive new cards if you make changes to your coverage. If you make no changes, please keep the cards that you currently have.

Q: Will I have a card for me and one for my spouse for medical and prescription drugs?

A: Yes. You and your spouse will each receive your own separate medical and prescription drug cards.

Q: Do I have to see network providers?

A: There are no network providers in the NEBCO plan. You can choose to see any provider that you wish.

Q: If my spouse and I are both 65 or older, will we have to select the same plan?

A: If you and your spouse are both 65 or older, you must select the same plan. For example, if you wish to enroll in the NEBCO Premier Plan, then your spouse will also need to enroll in the Premier Plan.

Q: If I retire in the middle of the year will my out of pocket costs such as deductibles and out-of-pocket maximum as an employee apply to my costs as a retiree?

A: No. If you retire mid-year, the amounts applied to your deductibles and out-of-pocket maximum under the CIGNA Plan will not be applied to the deductibles and out-of-pocket maximum under the NEBCO Plan. The CIGNA plan is self-insured by RTI and the NEBCO is a fully insured plan and there is no transfer of out-of-pocket costs between the two plans.

Filing Claims

Q: Do I have to file a claim each time I see the doctor?

A: If your doctor accepts Medicare, you do not have to file claim forms. Simply present your Monumental Medical ID card when you go to your doctor. Medicare pays the provider the Medicare portion of your claim and forwards the balance due electronically to Monumental’s claim administrator, who then directly pays the difference.

Enrolling in Coverage

Q: How do I enroll?

A: NEBCO will mail an open enrollment packet to you before November 2. This packet will include a cover letter, creditable coverage letter, open enrollment form, the 2010 Spectrum

Retiree Benefit Booklet, and this Frequently Asked Questions Guide. **Note: You don't need to return the enrollment forms to NEBCO unless you are requesting changes to your benefits. If you don't want to make any changes to your coverage, do not mail back the enrollment form; your coverage will remain the same. If you are making changes, complete the open enrollment form and return to NEBCO in the envelope provided.**

If you have questions, contact NEBCO at 1.888.883.3757.

Retirees and/or Spouses Under Age 65

CIGNA Medical Plan

During open enrollment, you may contact CIGNA at 1.800.401.4041 or go online to www.mycignaplans.com to learn more about the CIGNA Open Access PPO plans. Your *user ID* is **RTI2010** and your *password* is **cigna**.

Q: How do the Open Access PPO Plans work?

A: To understand how the Open Access Plans work, there are some important terms to first understand:

- A deductible is the amount that you must pay for covered services each year before the medical plan provides any benefit for the service (other than those covered with a copay).
- Copay is a specific dollar amount that you pay each time you use a covered service; services reimbursed by a copay are not subject to a plan deductible.
- Coinsurance is the amount that the medical plan will pay for certain services after you meet the annual plan deductible. The medical plan will pay a certain percentage (coinsurance) and you'll pay the remaining percentage (coinsurance).
- An out-of-pocket maximum is the maximum amount you must pay for covered services each year before the medical plans pays for services at 100% for the remainder of the year.

Q: What are the annual deductibles, coinsurance, and out-of-pocket maximums under the CIGNA Open Access Plans?

A: Under the CIGNA Open Access PPO Plans, the deductibles, coinsurance, out-of-pocket maximums, and copays are as shown in the table on the following page:

Deductibles and Copayments Under the CIGNA Open Access Plans

Plan Feature	Open Access Premier		Open Access Standard	
	In Network	Out of Network	In Network	Out of Network
Annual Deductible				
Individual	\$250	\$1,000	\$500	\$750
Family	\$500	\$3,000	\$1,000	\$2,250
Coinsurance				
CIGNA's portion/your portion	90%/10%	70%/30%	80%/20%	60%/40%
Annual Out-of-Pocket Maximum				
Individual	\$1,500	\$7,500	\$3,000	\$7,500
Family	\$3,000	\$15,000	\$6,000	\$15,000
Copays				
Primary Care Physician	\$15	70%/30% after deductible	\$25	60%/40% after deductible
Specialist	\$30	70%/30% after deductible	\$50	60%/40% after deductible

Q. What happens if I go out of network for treatment?

A: Your plan reimburses covered services from doctors, hospitals, and other health care professionals that do not participate in the CIGNA Open Access network. However, except in the case of an emergency, your share of the cost of these out-of-network services (e.g., co-payments, coinsurance, and deductibles) is higher compared with what you pay for in-network services. Under the CIGNA medical plans, only charges up to the maximum reimbursable charge¹ for the non-emergency out-of-network service are considered for reimbursement. This maximum reimbursable charge is based on the amount that doctors and other health care professionals in your geographic area charge for the same service. You are currently responsible for all costs above this maximum reimbursable charge. Keep in mind that these costs do not apply to your out-of-pocket maximum or deductibles.

¹ The “maximum reimbursable charge” is based on a **percentage of a fee schedule developed using a Medicare-based methodology**. It is similar to Medicare-allowable charges. This change will result in a higher increase in your cost for out-of-network services and supplies. You will still be responsible for any amount above that maximum, as shown on the Explanation of Benefits form that you will receive when a claim is paid, in addition to applicable co-payments, deductibles, and coinsurance.

Q. Can you provide an example of how the “maximum reimbursable charge” works?

A: Below is an example to help you understand how the maximum reimbursable charge works. Let’s assume you are enrolled in the Standard Plan. If you go out of network for treatment, the Plan’s coinsurance is 60% and your coinsurance is 40%.

Cost Comparison: In-Network vs. Out-of-Network Costs Based on the Maximum Reimbursable Charge		
<p>With the change in how out-of-network health care professionals will be paid, your costs for out-of-network services will increase. The examples below compare costs for typical services. For specific expenses under your plan, please see your benefits materials.</p> <p>When you receive covered services from out-of-network health care professionals:</p> <ul style="list-style-type: none"> Your share of the costs (e.g., co-payments, coinsurance, and deductibles) is higher compared with what you pay for in-network services. Your care is covered only up to your plan’s “maximum reimbursable charges.” You are responsible for any amount above that maximum, in addition to applicable co-payment, deductibles, and coinsurance amounts. The provider can bill you for the difference between the billed charge and the maximum reimbursable charge under your benefit plan. 		
Outpatient Hospital Charges	In-Network	Out-of-Network
Outpatient Hospital charges	\$250 is the normal billed charge. The CIGNA discounted charge is \$100.	\$250
Maximum Reimbursable Charge under your plan	N/A	\$105
Amount above maximum reimbursable charge that is your responsibility	N/A	\$145
Your coinsurance obligation (assuming 20% in-network and 40% out-of-network coinsurance)	20% of \$100 = \$20	40% of \$105 = \$42
Your total cost	\$20	\$187 (\$145 + \$42)

Q: If I retire in the middle of the year, will my out-of-pocket costs such as deductibles and out-of-pocket maximum as an employee apply to my costs as a retiree?

A: Yes. If you retire mid-year, the amounts applied to your deductibles and out-of-pocket maximums under the CIGNA plan will continue to apply as long as you remain with the CIGNA plan. If you turn 65 during the year and change to the NEBCO plan, the deductibles will start over.

Q: How will my drugs be covered?

A: Your prescription drugs will be covered as shown in the following table:

**Coverage and Deductibles for Retail and Mail-Order Drugs
Under the CIGNA Open Access Plans**

Prescription Drug Level	Open Access Premier		Open Access Standard	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail (30-day supply)				
	Coverage and Deductibles			
Generic	\$10	No coverage	\$10	No coverage
Preferred Brand	\$35	No coverage	\$50	No coverage
Non-preferred Brand	\$70	No coverage	\$100	No coverage
Prescription Deductible*	\$25 (individual) \$50 (family)	N/A	\$50 (individual) \$100 (family)	N/A
Mail-Order (90-day supply)				
	Coverage and Deductibles			
Generic	\$20	No coverage	\$20	No coverage
Preferred Brand	\$70	No coverage	\$80	No coverage
Non-preferred Brand	\$140	No coverage	\$160	No coverage
Prescription Deductible	No deductible	N/A	No deductible	N/A

*There will no longer be a deductible for generic drugs filled at a retail pharmacy. Deductibles will still apply to preferred brand and non-preferred brand drugs.

Q: Can you compare how deductibles, coinsurance, and out-of-pocket maximums work under the Open Access Plans?

A: Open Access Premier and Standard Plans:

If you are enrolled in *individual coverage* under the Open Access Premier and Standard Plans, when you meet the annual deductible, the plan will then pay the coinsurance for certain services. Keep in mind some services like doctor visits and prescriptions are only subject to a copay and are not subject to an annual plan deductible.

If you are enrolled in *family coverage* under the Open Access Premier and Standard Plans, you and only one additional covered dependent must meet the individual annual deductible before the family deductible is met. In other words, the individual deductible applies but only two family members have to meet it.

For example, let's assume you have four family members and you enroll in the Open Access Premier Plan. You meet your annual in-network deductible of \$250 and your spouse meets his annual deductible of \$250. At this point, your family deductible has been met and the medical plan will then pay 90% for any covered services for all family members. The out-of-pocket maximum works the same—once two family members have enough expenses to reach the family out-of-pocket maximum, CIGNA pays the rest for the remainder of the year.

Note: The annual deductible *does not* apply to the out-of-pocket maximum.

Q: How does CIGNA offer mail-order drugs?

A: CIGNA HealthCare provides mail-order drugs through CIGNA Tel-Drug. A wide range of resources are available through Tel-Drug: CIGNA's QuickSwitch program; online tools via www.myCIGNA.com such as cost comparisons, drug lists, and alternative drug suggestions; and access to a Tel-Drug pharmacist at any time either online or via a toll-free line.

You have two options when you use Tel-Drug for the first time:

- You can submit a new Tel-Drug order form along with a 12-month prescription, or
- You can call Tel-Drug at 1.800.835.3784 to request to have your prescriptions switched to Tel-drug. The Tel-drug representative will contact your provider and obtain the prescription information on your behalf.

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

A: You may fill a prescription at any one of CIGNA's participating pharmacies, such as Walgreens, CVS, etc., as of the plan's effective date. To locate a participating pharmacy, call CIGNA customer service toll-free at 1.800.244.6224 or access the provider information online at www.cigna.com or www.myCIGNA.com.

Q: Will I get a new medical ID card and prescription drug card?

A: If you remain enrolled in the same plan and make no changes, you will not receive a new ID card. If you change medical plans—for example, switch from the Premier Plan to the Standard Plan, or change the level of coverage—you will receive a new medical ID card before January 1, 2010.

Q: How do I get additional ID cards for my family?

A: You can call customer service toll-free at 1.800.244.6224 or log onto Cigna's Web sites, www.cigna.com or www.myCIGNA.com, to request additional or replacement ID cards. Temporary ID cards can be printed through the member Web site, www.myCIGNA.com.

Q: What if I need to visit my doctor or file a prescription before I receive my ID card?

A: CIGNA's goal is to deliver permanent ID cards on or before January 1 to those who change medical plans for 2010. Once your eligibility is loaded into CIGNA's eligibility system in late December, you can print temporary ID cards from www.mycigna.com. Ask participating providers, including pharmacies, to call CIGNA's toll-free customer service number at 1.800.244.6224 to verify your eligibility in the event that you have not received your

identification card. The customer service representative will verify your eligibility, and once your eligibility is confirmed, your prescription can be processed.

CIGNA Network

Q: Will I have to select a primary care physician (PCP) in the PPO plans?

A: No. The “open access” nature of CIGNA’s Open Access Plus network means you do not have to select a PCP. You can go to any network doctor. (You can see a doctor not in the network, but you will pay more for out-of-network medical services.)

Q: What types of doctors are considered to be PCPs?

A: CIGNA considers the following doctors to be PCPs:

- General practitioner
- Family practitioner
- Internist
- Pediatrician

Note: OB-GYN visits will be subject to either the PCP or specialist copay depending whether the provider contracts with CIGNA as a PCP or as a Specialist.

Q: How do I verify that my doctors or medical providers participate in the CIGNA network?

A: CIGNA has many network plans; however, the official name of the CIGNA network for the medical plans offered to RTI staff is **CIGNA Open Access Plus network**. You may access the CIGNA Web site at www.cigna.com, call CIGNA at 1.800.244.6224, or contact your medical providers directly to verify whether they participate in the CIGNA “**Open Access Plus**” network. If you speak to your doctor, ask specifically if he or she participates in the CIGNA Open Access Plus network.

Q: What happens if my doctor is not in the CIGNA network?

A: To receive maximum benefit, you should select a doctor from the list of participating Open Access Plus providers. Participating providers must meet standards to become a part of the Open Access Plus network. If your doctor is not in the Open Access Plus network, ask him or her to join. Keep in mind that you can continue seeing your current doctor even if he or she is not a participating provider, but you will pay much more for out-of-network medical services.

Q: Is the network the same for both medical plans?

A: Yes. Both medical plans for CIGNA HealthCare are based on CIGNA's national Open Access Plus network of 645,000 physicians (primary and specialty care), nearly 5,000 hospitals, 59,000 behavioral health providers, and 57,000 pharmacies, including all the major chains. The Open Access Plus network is one of three networks offered by CIGNA and offers the broadest network coverage.

Q: Will I need referrals to see specialists or other providers?

A: No. Since the Open Access Plus benefit plan is an open access program, no referrals are required to access services from specialist providers. You may receive care from an in-network (participating) or out-of-network (non-participating) provider. When you seek care from an in-network provider, you minimize the amount you have to pay out of your own pocket.

Q: What happens if I don't have any access to network providers in the area I live?

A: Based on a provider access analysis conducted during the vendor selection process and CIGNA's broad Open Access Plus network, each member should have adequate access to a variety of providers locally. In the event this does not hold true, you can seek care from any of CIGNA's nationwide Open Access Plus network providers—in your residential area or possibly where you work.

Emergency and Urgent Care

Q: What happens if I need emergency care under CIGNA's plans?

A: When a situation is severe and time is critical, you should seek care at the closest facility.

If you experience a truly life-threatening emergency and receive care at a non-network facility, treatment will be covered at the in-network benefit level, regardless of where the service was provided.

CIGNA uses a universal standard for emergency care, known as the “prudent layperson” standard, to administer all coverage decisions for emergency care. Under this standard, an emergency is defined as an accident or sudden illness that a person with an average knowledge of medical science reasonably believes needs to be treated right away or serious medical complications could result.

Q: Does CIGNA cover urgent care if I am traveling?

A: Urgent care is any unforeseen and medically necessary care rendered to a member to treat symptoms that occur unexpectedly and are severe enough that delaying treatment could cause a more serious medical problem. If services are deemed necessary according to these terms, benefits will apply at the in-network benefit level.

If services are deemed to be non-life threatening and you see an out-of-network provider, your benefit will be paid at the out-of-network level.

Filing Claims

Q: Will I need to file a medical claim form under CIGNA?

A: No. Contractually, participating in-network providers must submit claims to CIGNA upon the completion of care. Typically, providers send their claims either electronically or via mail. You will not be required to file a claim for providers unless they are out of the network.

Q: Will I be able to view my claims online? What other tools will be available to me?

A: Yes. You will have access to view your health care claims for both plan options (Premier and Standard) online via www.myCIGNA.com. Please make sure you set up an account through this Web site to access information about your medical plan.

Mental Health and Substance Abuse Coverage

Q: Will I need to get pre-authorization for mental health and substance abuse services under CIGNA?

A: Outpatient Care

Pre-authorization is *not* needed for routine outpatient care (e.g., regular individual or group counseling sessions) with Cigna Behavioral Health (CBH).

Inpatient Care

Pre-authorization *is* required for inpatient care with CIGNA Behavioral Health (CBH). The CBH approach to inpatient management follows a traditional utilization review process, while adding advocacy and targeted interventions that reinforce the importance of treatment goals and aftercare planning.

Inpatient care managers work closely with the treating facility as well as primary care physicians and other medical specialists to address the participant's clinical needs. Mixed services protocols are discussed and regular contact maintained. Progress in meeting treatment goals is closely monitored and adjustments are made as the participant's condition changes.

CBH manages inpatient utilization through medical necessity indicators for appropriate treatment. CBH follows CIGNA's Level of Care Guidelines in considering the appropriateness of any level of care—all care must be medically necessary.

Q: Will treatment for mental health and substance abuse be subject to annual limitations?

A: In 2010, the 30-day annual limitation for inpatient treatment for mental health and substance abuse and the 30-visit annual limitation for outpatient treatment will no longer apply. Treatment for mental health and substance abuse will be covered the same as any other illness. For example, if you are admitted into the hospital and if your stay should exceed more than 30 days, your case will be managed by CIGNA Behavioral Health (CBH). You may contact CIGNA Behavioral Health at 1.800.926-2273. You will work directly with a case manager who will evaluate the necessity and duration for the hospital admission and any subsequent treatment.

Enrolling in Coverage

Q: How do I enroll?

A: You will receive an enrollment form in your RTI packet of information. **Please complete the form and return it to Flores & Associates in the envelope provided in the packet by November 16.**

Q: What happens if I don't enroll in 2010 coverage?

A: You will automatically be enrolled in the same plan option (Premier or Standard) that you had for 2009. You will remain at the same level of coverage that you had for 2009 (i.e., individual or employee/spouse).

Questions About Other Benefit Plans

Vision

Q: What vision procedures are covered by CIGNA instead of Ameritas-VSP?

A: The CIGNA Open Access Plans cover treatment by an ophthalmologist or optometrist for a medical disease or injury of the eye only. The Open Access Plans do not cover routine eye exams, eyeglasses, contact lenses, or surgery that is intended to enable you to see better without glasses or other vision correction including radial keratotomy, laser, and refractive eye surgery. These services are provided under Ameritas-VSP.

Q: How often are eye exams covered under the Ameritas-VSP plan?

A: Eye exams are covered once every 12 months based on the date of the receipt of the services.

Q: How often are frames covered under the Ameritas-VSP plan?

A: Ameritas-VSP covers one set of frames every 24 months based on the date of the receipt of services or materials.

Q: Are exams given by ophthalmologists covered under VSP?

A: Yes. If the ophthalmologist is a VSP member, then the exam is covered at 100% after a \$10 copay. If the ophthalmologist is not a VSP member, then you will be required to pay the provider in full at the time of service. Ameritas-VSP will reimburse you up to \$52.

Q: Are there any other limitations that I need to know about under VSP?

A: Yes. Covered expenses will not include and no benefits will be payable for expenses incurred for:

- More than one eye exam in any 12-month period.
- More than one pair of lenses in any 12-month period.
- More than one set of frames in any 24-month period.
- More than one set of contact lenses in any 12-month period. When chosen, contact lenses will be in lieu of any other lenses benefit during the 12-month period and in lieu of any other frame benefit during the 24-month period. When lenses are chosen, expenses for contact lenses are not “covered expenses” during the 12-month period.

Q: How do I file an out-of-network claim for VSP?

A: To ensure timely reimbursement, log on to www.vsp.com and use their online Out-of-Network Reimbursement Form or send the following information to VSP:

- An itemized receipt listing the services you received
- The name, address, and phone number of the non-VSP provider
- The covered member’s I.D. number
- The covered member’s name, phone number, and address

- The name of the organization that provides your VSP coverage (Ameritas-VSP)
- The patient's name, date of birth, phone number, and address
- The patient's relationship to the covered member (such as "self," "spouse," or "child").

Please keep a copy of the information and mail the originals to the following address:

VSP
 Attn: Out-of-Network Claims
 P.O. Box 997105
 Sacramento, CA 95899-7105

Most out-of-network claims must be submitted to VSP within 6 months for reimbursement.

Dental

Q: What are the differences between the Standard and the Premier Dental Plans offered through Ameritas?

A: For 2010, RTI will continue to offer the Premier Dental Plan in addition to the Standard Plan. The Premier Dental Plan allows you to purchase additional coverage for services such as orthodontia for children up to age 19 and lower your out-of-pocket expenses for certain services. However, with the Premier Plan, your monthly premium (cost) and your annual calendar year maximum are higher.

Note: If you elect the Premier Plan, you must remain enrolled in this Plan for 2 years. A 2-year lock-in period applies. If you enroll in this coverage for 2010, you must remain enrolled in the Premier Plan through the end of 2011.

Q: What are the advantages of using a network dental provider through the Ameritas Dental Plan?

A: By using an Ameritas PPO provider:

- Any member who goes to a PPO provider will be billed at discounted rates for procedures performed by that provider.
- A PPO provider cannot back-bill the patient for the difference between the dentist's normal charges and the discounted fees that the dentist agreed to charge as an Ameritas provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balance owed for deductibles, coinsurance, or any amount exceeding the annual maximum benefits.

Q: What happens if I don't use a network dental provider?

A: You and your covered dependents may use any licensed dental provider you choose. There are no differences in the coinsurance, deductibles, and maximums on either plan whether you use an in-network provider or not. Out-of-network providers can charge their standard fees for any service. Out-of-network benefits are reimbursed at the highest available usual,

customary, and reasonable (UCR) allowance. Generally, 9 out of 10 dentists in a zip code charge at or below RTI's reimbursement amount. You can feel comfortable that very few additional charges will be billed to you based on the amounts allowed by the plan.

Q: Will Ameritas mail dental cards? Do we get new cards if we are already enrolled?

A: In late December, Ameritas will mail dental cards only to retirees who are making changes to their coverage, such as adding a new dependent to coverage or switching to the new Premier dental plan.