



Retiree Benefit Options



Spectrum

RTI Benefit Options to Meet Your Changing Needs

2010

Important Terms

Coinsurance	The percentage share of eligible medical expenses that the plan pays for a covered service.
Coinsurance limit	A specific dollar amount of the coinsurance you have paid for covered services in a benefit period. This amount does not include deductibles, charges in excess of allowable amounts, or amounts paid for non-covered services.
Copay	A specific dollar amount that you pay each time you use a covered service; services reimbursed with a copay are not subject to a deductible.
Deductible	The amount that you must pay for covered services each year before the plan provides any benefit for the service.
Out-of-pocket maximum	The maximum employee liability for the cost of services within the plan, which includes coinsurance only; generally, it does not include co-pays and deductibles. NOTE: The annual deductible does not apply to the out-of-pocket maximum under the Premier and Standard Plans.
Preferred provider organization (PPO)	A PPO is a traditional insurance plan with deductibles and coinsurance features. You may choose any licensed providers for your medical care, and benefits are not restricted to any service area.
Premium	The cost of insurance that the retiree pays, usually monthly.

Please use your Summary Plan Description for more detailed definitions or contact hrhelp@rti.org for assistance.

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If information in this booklet conflicts with information in the Summary Plan Descriptions or plan documents, the Summary Plan Description or plan documents prevail. This information is up-to-date as of November 2009. To verify the most up-to-date Spectrum Benefits information, please contact hrhelp@rti.org or 919.541.1200.

Introduction: Spectrum Benefits Program

RTI International offers a comprehensive benefits package through our **Spectrum Benefits** program for retirees and their eligible dependents. RTI's **Spectrum Benefits** program provides a flexible approach to your benefits, allowing you to select coverage levels that best meet your needs.

This section provides a brief overview of open enrollment, the **Spectrum Benefits** options, and what's new in benefits for 2010. The remainder of the booklet provides information on the medical, vision, and dental plans offered, as well as the benefits costs.

Retiree Benefit Program Eligibility

RTI offers a Retiree Benefits Program to employees who have retired from employment with RTI on or after age 55 with at least 10 years of service, or on or after age 60 with at least 5 years of service. This program applies only to U.S.-based employees with medical and/or dental coverage at the time of retirement.

Retiree medical coverage is provided by NEBCO to Medicare-eligible retirees and/or spouses age 65 and older and by CIGNA to retirees and dependents under age 65. Dental coverage is provided by Ameritas.

You may also enroll eligible dependents, who include your:

- Spouse
- Unmarried children from birth to the end of the month during which they turn 19, including legally adopted, foster, and step children, children placed for adoption, and children for whom legal guardianship has been awarded to you

- Unmarried dependent children from their 19th to 26th birthday if they attend a licensed vocational or technical school or accredited school, college, or university as full-time students
- Unmarried children who are mentally or physically handicapped and incapable of self-support, regardless of age.

There are four ways to cover yourself and your eligible dependents:

4 Levels of Coverage for You and Your Dependents	
Individual	Covers retiree only
Retiree/spouse*	Covers retiree and spouse
Retiree/children	Covers retiree and all dependent children
Family	Covers retiree, spouse, and retiree's dependent children

*Coverage is available only for legal spouse at time of retirement. Domestic partners are **not** eligible to participate in RTI Retiree Benefits Program unless such participation is required by state or local laws.

Retirees who meet certain eligibility requirements are entitled to medical premium credits, as shown in Table 1 on the following page. Your medical premiums will be deducted from your credits; once you exhaust your credits, you will pay the full premium to NEBCO or Flores & Associates by check. (Flores will continue to administer medical and dental premium payments for retirees/dependents under age 65.)

Table 1. Retiree Healthcare Program Eligibility Requirements and Premium Credits

If you meet the following age, retirement date, and service requirements...	Then your medical premium credits are...
If you are at least age 60 and have 5 years of service or age 55 with 10 years of service (<i>and retire after January 1, 2004</i>)	\$1,000 per year of credited regular service up to \$20,000.
If you are severed from RTI service at age 50–65 on or after January 1, 2005, and have 10 years of creditable service	\$1,000 per year of credited regular service (prior to severance) up to \$20,000

The premium credits shown above apply **only** to *retiree medical premiums*, not dental premiums and not spouse or dependent medical premiums.

The premium credits cannot be used for dental premiums, even if you do not continue medical coverage. You may continue dental coverage by paying the full premium cost. Any unused credits **will not** be paid out in cash, nor can they be used to pay insurance premiums for dental or other medical coverage purchased outside of RTI.

See Tables 6 and 7 in the Benefits Costs section for costs for individual and retiree/spouse coverage. If you have any questions about costs for retiree/children or family coverage, please contact HR Help at hrhelp@rti.org or 919.541.1200 or 1.800.334.8571, ext. 21200.

Important

- If you choose not to be covered by RTI’s medical insurance because you have coverage elsewhere, you **may not** rejoin the RTI Retiree Medical Plan at a future date.
- Retirees/spouses age 65 and over must be enrolled in Medicare Parts A and B. RTI’s medical plan through NEBCO is secondary to Medicare Parts A and B.

Open Enrollment

Each year during open enrollment you have the opportunity to make changes to your current levels of coverage. **Spectrum Benefits** selections you make during open enrollment become effective on January 1, 2010, and continue through December 31, 2010.

When enrolling in coverage for 2010, keep this in mind:

- **To ensure you are enrolled in the medical plan option of your choice for 2010, please review your benefits information thoroughly.** If you do not submit an enrollment form for 2010 coverage, you will be enrolled in the same plan option (Premier or Standard) that you had for 2009. You will also be enrolled in the same level of coverage that you had for 2009 (i.e., individual or retiree/spouse). It is very important for you to make an election for medical coverage in 2010 if you wish to make any changes for your coverage.
- **If you waived medical coverage for 2009 or before, you are not eligible to rejoin the medical plan. This also applies to the dental plan—if you previously waived this coverage, you will not be eligible to rejoin the plan.**

What's New in Benefits for 2010

Medical

For Retiree/Spouses Age 65 and Older (NEBCO):

- No changes. NEBCO will continue to be the third party administrator for all Medicare-eligible retirees.

For Retirees/Dependents Under Age 65 (CIGNA):

- For 2010, the two CIGNA medical plans, Premier and Standard, will continue to be offered to you. You'll find a few changes to these plans.
- Premier and Standard
 - If you purchase *generic* drugs at a retail pharmacy, you'll see some cost savings since the annual deductibles will no longer apply for generic drugs; however, the annual deductibles will still apply for preferred brand and non-preferred brand drugs.
 - Beginning in 2010, there is no longer a 30-day annual limitation for inpatient treatment for mental health and substance abuse, and no longer a 30-visit annual limitation for outpatient treatment. Treatment for mental health and substance abuse will be covered like any other illness.
 - Next year payment for out-of-network providers will change. Beginning next year, only charges up to the "maximum reimbursable charge" for non-emergency out-of-network services will be considered for reimbursement. The maximum reimbursable charges will be based on a percentage of a fee schedule that uses a Medicare-based methodology. It is similar to Medicare-allowable charges. This change will result in a larger increase in your costs for out-of-network services and supplies. You will still be responsible for any amount above the maximum reimbursable charges for claims that are paid, in addition to applicable copayments, deductibles, and

coinsurance. Using in-network providers can lower your costs. Always check with your providers to find out if they participate in the CIGNA Open Access networks. For an example of how the maximum reimbursable charge works, see the *Retirees Open Enrollment Frequently Asked Questions and Answers Guide*.

- Social Security numbers will now be required for all dependents, according to the Centers for Medicare and Medicaid Services. RTI is required to provide social security numbers to insurance carriers for reporting purposes.

Vision

No changes. Ameritas-VSP will continue as the vision carrier. Retirees/spouses age 65 and older and retirees/dependents under age 65 will continue to have the same vision coverage provided by Ameritas-VSP.

Dental

Ameritas will continue as the dental carrier. All retirees/spouses (regardless of age) can choose between two Ameritas dental plans:

- The Standard Plan
- The Premier Plan.

The Premier Plan allows you to purchase additional coverage for services such as orthodontia for dependent children up to age 19, lower your out-of-pocket expenses for certain services, and increase your annual calendar year maximum at a higher premium cost.

NOTE: If you elect the Dental Premier Plan, you must remain enrolled in this Plan for 2 years. For example, if you enrolled in this coverage for 2009, you must remain enrolled in the Premier Plan through the end of 2010. If you enroll in the Premier Plan for the first time in 2010, you'll remain enrolled in the Plan through 2011.

2-Year Lock-in Applies

Important

- NEBCO will continue to administer medical and dental premium payments for retirees/spouses age 65 and older.
- Flores & Associates will continue to administer medical and dental premium payments for retirees/dependents under age 65.
- If you are enrolled in any of the medical plans (NEBCO or CIGNA), your basic vision coverage is offered through Ameritas–VSP. Contact Ameritas–VSP Member Services at 1.800.877.7195 if you have any questions about your vision coverage. Check for participating providers at the VSP Web site, www.vsp.com.
- If you are enrolled in one of the CIGNA Open Access medical plans and are under age 65, your mental health and substance abuse coverage is offered through CIGNA Behavioral Health. You must obtain prior authorization for inpatient mental health and substance abuse benefits by calling 1.800.926.2273. You can identify CIGNA mental health and substance abuse providers at www.cignabehavioral.com.
- Contact hrhelp@rti.org if you have questions about your benefit coverage. You can also call **919.541.1200** or **1.800.334.8571, ext. 21200**. The address for Human Resources is:

RTI International
Human Resources
300 Park, 1st Floor
PO Box 12194
Research Triangle Park, NC
27709-2194



Medical Plan for Medicare-Eligible Retirees Age 65 and Older

NEBCO Premier and Standard Plans

For many retirees, one of the most important decisions you must make is choosing the medical plan option that is best for you and your family.

Through NEBCO, you can select from two medical options: the **Premier Plan** and the **Standard Plan**. You must be enrolled in both Medicare Part A and Medicare Part B. Both plan options coordinate directly with Medicare. Medicare pays first, and then NEBCO pays. Table 2 compares the NEBCO Premier and Standard Plans, and Table 3 compares the copays for prescription drugs under the two plans.

Table 2. NEBCO Medical Plans Comparison

	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.

Table 3. NEBCO Prescription Drug Comparison

	NEBCO Premier Plan		NEBCO Standard Plan	
	Retail (30-day) (no deductible)	Retail (90-day) or Mail Order	Retail (\$50 deductible applies)	Retail (90-day) or Mail Order
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: Prescription drug coverage is provided through United American.



Medical Plan for Non-Medicare-Eligible Retirees Under Age 65

CIGNA HealthCare Open Access Plans

You can select from two CIGNA HealthCare Open Access PPO plans. This coverage can protect you and your family from high and often unexpected medical expenses.

- **Open Access Premier Plan:**
\$250 individual/\$500 family annual deductible for in-network coverage
- **Open Access Standard Plan:**
\$500 individual/\$1,000 family annual deductible for in-network coverage

The two medical plan options are based on CIGNA's Open Access Plus Network—a group of doctors, hospitals, and other health care providers. The CIGNA Open Access Network includes 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. When you need medical care, you decide to use either the providers in the network or seek services from a provider outside the network. The key point is you always have a choice.

You minimize your costs when you use hospitals and doctors in the Open Access Plus Network. You can select a primary care physician (although this is not required) to coordinate your care. No referrals are required to access services from network specialists.

You can seek care outside the network, but keep in mind that you will pay higher out-of-pocket costs when you use non-network providers.

Open Access in-network advantages:

- Higher benefits—You pay less for in-network care.
- Quality care—Network doctors are carefully screened and continually monitored by the network manager.
- Preventive care—Physical examinations, mammograms, well-baby care, immunizations, and other preventive services are covered.
- Convenience—No claim forms to file, and hospital precertification requirements are handled by your network doctors.

Table 4 compares the benefits between the two CIGNA Open Access Plans. It is intended only to highlight your benefits and should not be relied upon to fully determine coverage.

Table 4. CIGNA Medical Plans Comparison

	CIGNA Open Access Premier		CIGNA Open Access Standard	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	\$250	\$1,000	\$500	\$750
Family	\$500	\$3,000	\$1,000	\$2,250
Out of Pocket				
Individual	\$1,500	\$7,500	\$3,000	\$7,500
Family	\$3,000	\$15,000	\$6,000	\$15,000
Copays				
PCP	\$15	70/30%*	\$25	60/40%*
Specialist	\$30	70/30%*	\$50	60/40%*
Coinsurance (CIGNA's portion/your portion)				
MRI, CT/PET Scans	90/10%*	70/30%*	80/20%*	60/40%*
Hospital–Inpatient	90/10%*	70/30%*	80/20%*	60/40%*
Hospital–Outpatient	90/10%*	70/30%*	80/20%*	60/40%*
Emergency Room	\$150	\$150 (for true emergency only; otherwise, 70/30%*)	\$150	\$150 (for true emergency only; otherwise, 60/40%*)
Mental Health and Substance Abuse (MH/SA) Combined				
MH/SA–Inpatient	90/10%*	70/30%*	80/20%*	60/40%*
MH/SA–Outpatient	\$30 copay	70/30%	\$40 copay	60/40%*
Preventive Benefit	Office copay	N/A	Office copay	N/A
Retail Pharmacy				
Generic	\$10	No coverage	\$10	No coverage
Preferred Brand	\$35	No coverage	\$50	No coverage
Non-preferred Brand	\$70	No coverage	\$100	No coverage
Deductible**	\$25 (individual) \$50 (family)	No coverage	\$50 (individual) \$100 (family)	No coverage
Mail-Order Pharmacy				
Generic	\$20	No coverage	\$20	No coverage
Preferred Brand	\$70	No coverage	\$80	No coverage
Non-preferred Brand	\$140	No coverage	\$160	No coverage
Deductible	\$0	N/A	\$0	N/A

* After the plan deductible is met, CIGNA and you share the cost of services. The first number is CIGNA's percentage of coinsurance, and the second number is the percentage you pay.

**There will be no deductible for generic prescriptions purchased at retail pharmacies. Deductibles will still apply to preferred brand and non-preferred brand drugs.

Mental Health and Substance Abuse Coverage

Mental health and substance abuse benefits for CIGNA members are provided through CIGNA Behavioral Health (www.cignabehavioral.com), which provides inpatient and outpatient services. Prior authorization for inpatient mental health and substance abuse benefits is required; call **1.800.926.2273** to obtain prior authorization. Prior authorization for routine outpatient care such as individual and group counseling is not required.

Vision Plan

Protecting your eyesight is very important, which is why you should have your vision checked on a regular basis. If you elect one of the NEBCO or CIGNA medical plans, you and any covered dependents are also automatically provided with vision coverage through Ameritas-VSP. Table 5 shows a summary of your in- and out-of-network vision plan benefits.

To use your VSP benefit, make an appointment with your provider and tell the provider you are a VSP member. Ameritas-VSP will take it from there. If you use a network provider, you'll never have to show an ID card, fill out claim forms, or wait for reimbursement. Visit www.vsp.com for a list of providers. You may also go to a provider that is not in the VSP network, but benefits will be reduced.

Vision Plan Highlights

- Approximately 30,000 providers
- One-stop shopping: exams, frames, and lenses, plus discounts for additional services
- Personalized self-service on the Web
- Laser VisionCare Program
 - Educational information on the Web
 - Personalized evaluation from your doctor
 - Surgical care from credentialed laser centers
 - Up to 20 percent discount on LASIK and PRK laser vision correction procedures.

Limitations:

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

- Eye exam more than once 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
- Contact lenses more than once 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.

Table 5. Ameritas–VSP Benefits Summary

Benefits	In-Network Benefit	Out-of-Network Benefit
	You pay:	Ameritas-VSP pays:
Annual exams	\$10	Up to \$52
Material deductible for lens and/or frames	\$25	\$25
Ameritas-VSP pays:		
Frame	\$120 allowance toward any frame of your choice; you also get 20% off any amount over the allowance	Up to \$45 per pair
Single lenses	100%	Up to \$55 per pair
Bifocal lenses	100%	Up to \$75 per pair
Trifocal lenses	100%	Up to \$95 per pair
Lenticular lenses	100%	Up to \$125 per pair
Contact lenses—necessary	100%	Up to \$210 per pair
Contact lenses—elective	\$105 allowance toward the contact lens exam and contact lenses; you also get 15% off the contact lens exam before the allowance	Up to \$105 per pair
You receive:		
Frequency	Exam every 12 months; lenses every 12 months; frames every 24 months—based on the date of receipt for services or materials	

NOTE: Lenses **or** contacts may be covered at the highest level in the table above, but not both. There are additional charges for special features added to lenses (e.g., compounded, progressive).

Dental Plan

RTI offers two dental plan options that provide comprehensive benefits: the Standard Plan and the Premier Plan. The Premier Plan provides a higher level of coverage with a higher premium cost. Both plans are preferred provider organizations (PPOs) and offer a network of dentists through Ameritas. With both plans, you may visit any licensed dentist, whether he or she is considered in-network or out-of-network. However, you may want to use participating network dentists for lower out-of-pocket costs.

See Tables 6 and 7 in the Benefits Costs section for costs for individual and retiree/spouse coverage. If you have questions about costs for retiree/children or family coverage, please contact HR Help at hrhelp@rti.org or **919.541.1200** or **1.800.334.8571, ext. 21200**.

Important

- If you choose not to be covered by RTI's dental insurance because you have coverage elsewhere, you may not rejoin the plan at a later date.
- If you don't enroll your dependents when they are first eligible to be enrolled, you can't enroll them until the next open enrollment unless you experience a qualified family status change.
- If you and your spouse have other coverage, the RTI Dental Plan as either the primary or secondary payor will only pay up to the RTI plan maximum percentage. This means benefits will not be coordinated between the insurance companies to pay 100 percent of dental costs.

Premier Plan Benefits Summary

The Premier Plan pays:

- 100 percent of the usual, customary, and reasonable (UCR) charges for diagnostic/preventive services.
- 90 percent of the UCR charges for maintenance, oral surgery, and periodontic services.
- 60 percent of the UCR charges for prosthetic/complex restorative services.
- Up to \$1,750 after a \$50 per-member deductible is met each calendar year (no more than 3 times the individual deductible must be satisfied in each benefit period per family).
- Up to \$2,000 lifetime maximum orthodontia benefit per covered child up to age 19.

NOTE: If you elect the Dental Premier Plan, you must remain enrolled in this Plan for 2 years. For example, if you enrolled in the Premier Plan in 2009, you must remain enrolled in the Premier Plan through December 31, 2010. If you enroll in this coverage for 2010, you must remain enrolled in the Premier Plan through the end of 2011.

2-Year Lock-in Applies

Standard Plan Benefits Summary

The Standard Plan pays:

- 100 percent of the usual, customary, and reasonable (UCR) charges for diagnostic/preventive services.
- 80 percent of the UCR charges for maintenance, oral surgery, and periodontic services.
- 50 percent of the UCR charges for prosthetic/complex restorative services.
- Up to \$1,500 after a \$50 per-member deductible is met each calendar year (no more than 3 times the individual deductible must be satisfied in each benefit period per family).
- Up to \$1,000 lifetime maximum orthodontia benefit per covered child up to age 19.

Dental Rewards

Ameritas offers a dental rewards program for both the Standard and Premier Plans. Dental Rewards is a program that encourages good dental habits through regular dental check-ups. If you file at least one claim during the year and benefits paid are less than \$750 for the year, you will qualify for a reward of a \$250 increase in your annual maximum the following calendar year. This continues until you reach a total reward of \$1,000. The Dental Reward amount earned is reduced by any amount used in any year. Dental Rewards applies to each person who is enrolled in coverage, including any of your covered family members.

The program has a cap of \$1,000 on the total rewards you can earn. If you use the entire \$1,000 in rewards, you can earn rewards during the next year. Ameritas will use your annual dental maximum benefit first and then use any available funds from your Dental Rewards balance. All deductibles and coinsurance limitations still apply.

Dental Rewards Program		
Benefit Amount	\$750	Your annual dental benefits cannot exceed this amount.
Annual Carryover Amount	\$250	This is the total amount you can carry over to the following year's annual maximum.
Annual PPO Bonus	\$150	You can earn an additional bonus during the year if you see a network dentist.
Maximum Carryover	\$1,000	This is the maximum you can accumulate and carry over.

Important Notice: The following benefits are based on usual, customary, and reasonable (UCR) charges for your geographic area. You are strongly encouraged to contact the insurance carrier for preauthorization of services totaling over \$300.

Diagnostic and Preventive Services (paid at 100 percent of UCR under Standard and Premier Plans)

Because many dental expenses result from problems that could have been prevented by regular checkups, all diagnostic and preventive services are paid without a deductible. This part of the program helps you avoid such expenses by paying for preventive treatment. Diagnostic and preventive services include the following:

- Oral examinations, teeth cleaning, and scaling (2 per calendar year)
- X-rays (full series of X-rays every 3 years; bitewing twice per calendar year)
- Prophylaxis/fluoride application to prevent decay (twice per calendar year, with fluoride application limited to dependents under age 19)
- Sealants for first and second molars for members age 5 through 15
- Space maintainers (limited to dependents under age 19).

Maintenance, Oral Surgery, and Periodontic Services

(paid at 80 percent of UCR under the Standard Plan and 90 percent of UCR under the Premier Plan)

Your dental benefits cover many maintenance procedures, including the following:

- Palliative emergency treatment and emergency oral examination, not including permanent restorations or services
- Biopsies of oral tissue
- Routine fillings to restore diseased teeth
- Repair of removable dentures
- Re-cementing of inlays, crowns, and bridges
- Stainless steel crowns.

Your dental benefits cover many surgical procedures, including the following:

- Simple extractions
- Hemisection and apicoectomy
- Oral surgery, including surgical removal of teeth and maxillary or mandibular intrabony cysts and procedures performed to prepare the mouth for dentures
- General anesthesia administered in connection with a covered dental service, only if administered by an individual licensed to administer general anesthesia.

You can receive benefits for treatment of disease of the gum and tissues around the teeth, including the following:

- Gingival curettage
- Gingivectomy and gingivoplasty
- Osseous and mucogingivoplasty surgery
- Periodontal scaling and root planing.

Prosthetic and Complex Restorative Services (paid at 50 percent of UCR under the Standard Plan and 60 percent of UCR under the Premier Plan)

Your dentist may use an artificial device to restore your natural teeth. In this case, your dental program covers the following:

- Inlays and onlays (not part of bridge)
- Crowns (not part of bridge)—one per tooth every 5 years (must be over age 16)
- Denture adjustments and relining within 6 months of initial denture placement
- Dentures, full and partial and fixed bridges (once every 5 years)
- Fixed bridge repairs.

Orthodontia Services

(paid at 50 percent of UCR under Standard and Premier Plans)

Orthodontia services are payable at 50 percent of UCR for covered expenses. The plan has a lifetime maximum of \$1,000 under the Standard Plan and \$2,000 under the Premier Plan for orthodontia services for members up to age 19.

Making Changes to Your Benefits

Employee benefit elections must be made before the start of each calendar year during open enrollment. Your benefit elections will remain in effect through December 31, 2010. However, under certain restricted circumstances you may make limited changes in your coverage during the year by contacting HR Help at the number or address listed below:

hrhelp@rti.org

919.541.1200 or

1.800.334.8571, ext. 21200

RTI International

Human Resources

300 Park, 1st Floor

PO Box 12194

Research Triangle Park, NC

27709-2194

Benefits Directory

General RTI Retiree – Benefits Information

HR Help Desk919.541.1200
hrhelp@rti.org 800.334.8571, ext. 21200

Medical

NEBCO (for Retirees 65 and older)

Customer Care Center888.883.3757
www.membernetusa.com/RTI

CIGNA HealthCare (for Retirees under age 65)

Customer Services800.244.6224
www.cigna.com

Retiree Premium Payments

NEBCO (for Retirees 65 and older).....888.883.3757
www.membernetusa.com/RTI

Flores & Associates (for Retirees under age 65).....800.532.3327
www.flores247.com

Behavioral Health (Mental Health/Substance Abuse)

CIGNA Behavioral Health.....800.926.2273
www.cignabehavioral.com (for Retirees under age 65)

Vision

Ameritas–VSP

Member Services800.877.7195
www.vsp.com

Dental

Ameritas

Customer Relations800.487.5553
www.ameritasgroup.com

Retirement (RTI Retirement Plan and 403(b) Plan)

The Vanguard Group

Customer Service800.523.1188
www.vanguard.com

Fidelity Investments—403(b)

Customer Service800.343.0860
www.fidelity.com

VALIC, American General Financial Group—403(b)

Client Service800.448.2542
www.valic.com