

# BSA Aetna International Insurance Program Q&A

**1. How do we cancel our current CHIS insurance?**

Each employee will have to request coverage cancelation by email to [uniga@cern.ch](mailto:uniga@cern.ch) 30 days in advance of the end of the month, i.e. by May 31<sup>st</sup> for termination on June 30<sup>th</sup>.

**2. Can you provide a list of hospitals in Switzerland and France that are in the network?**

Yes. Please refer to the attachment “Direct Settlement France and Switzerland” for a list of facilities located in Switzerland and France that are in the network.

**3. For hospitalization, is there direct billing to the employee or a deductible?**

For Inpatient Hospital charges the following would apply:

PLAN FEATURES	In the U.S.		
	Outside the U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Hospital Services			
<b>Inpatient</b>	No charge	No charge after \$500 inpatient per confinement deductible	30% after deductible

If the hospital is in our direct settlement network, the hospital would submit the claim to Aetna. Aetna then pays its portion directly to the hospital and generates an Explanation of Benefits outlining what was paid by Aetna and what amount the member must pay.

**4. Is all in-network care on direct billing?**

Yes, all of our contracted international providers do accept direct settlement.

**5. Can the member submit a claim for reimbursement with the doctor’s bill if doctors do not submit claims?**

When a member uses a provider in the network, it is the provider’s responsibility to submit the claim on the member’s behalf.

Members can submit claims by either:

- completing an online claim form and uploading invoices and receipts or
- printing a claim form and submitting to Aetna along with invoices and receipts via fax or mail.

For submitting a claim online:

1. Members will need to go to their secure member website at [www.aetnainternational.com](http://www.aetnainternational.com) and complete a claim form, making sure it contains:
  - patient’s full name,
  - member Identification (ID) number
  - diagnosis
  - provider’s complete name and address
  - a thorough description of each service rendered, including the amount charged for each service, listed separately

2. Upload all relevant invoices and receipts by following the online instructions
  - Copy all relevant invoices and receipts legibly onto letter-sized paper
  - include the member ID number

Once the submission is complete, a reference tracking number will be issued for use in checking the status of the claim. Members will also be able to view claims history for any claims submitted online.

**6. Is reimbursement for out-of-network claims available via direct deposit into the member’s bank account?**

Reimbursement to the member is available via check, electronic funds transfer or by wire. Please note: Aetna does not charge a fee for electronic payments however, financial institutions may charge a processing fee. Members should verify any applicable fees with their financial institution.

**7. Why is there an out-of-pocket maximum (in-network) if everything is covered at 100%? What is not covered at 100% that's not indicated in that coverage chart?**

The out-of-pocket maximum for services received outside the U.S. has been removed.

**8. How does an emergency work at the hospital?**

There is no charge to the member for hospitalization outside the U.S. regardless of whether the hospital is in the direct settlement network or not. Hospitals participating in the direct settlement network will submit a claim on behalf of the member.

Should a member need to seek medical care via an Emergency Room, the following is applicable:

PLAN FEATURES	In the U.S.		
	Outside the U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Hospital Services</b>			
<b>Emergency Room</b>	No charge	No charge after \$100 copay	No charge after \$100 copay

Should the member’s visit to the Emergency Room result in an admittance to the hospital, then the following inpatient charges would apply to those services

PLAN FEATURES	In the U.S.		
	Outside the U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Hospital Services</b>			
<b>Inpatient</b>	No charge	No charge after \$500 inpatient per confinement deductible	30% after deductible

**9. What is the website for the Aetna International plan?**

[www.aetnainternational.com](http://www.aetnainternational.com)

**10. What is the transition of care process for employees who have an upcoming procedure after July 1 - such as as the birth of a child or a scheduled surgery? Do they need to pre-certify with the insurance company? Is there someone from Aetna that can reach out to this person?**

Aetna International has provided a Transition of Care (TOC) form to be completed by any doctor supervising an active course of treatment, including pregnancy past 24 weeks, who is not currently in Aetna’s direct settlement network. The form must be completed and submitted to Aetna within 90 days of when you enroll with the Aetna International Plan. You will receive notification from Aetna of approval or denial of your Transition of Care request in the mail. The form is attached.

Pre-certification is only required for certain types of non-preferred care and procedures performed in the U.S. For more information see the answer to question 16.

**11. Is there any better dental coverage that can be provided under the plan? It falls short of the CHS/Uniqa coverage? If so, what would the cost and coverage be?**

The maximum benefit is \$2000. The coverage is as follows:

PPO Dental			
PLAN FEATURES	Outside the U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
<b>Individual Deductible</b>	None	None	None
<b>Family Deductible</b>	None	None	None
<b>Type A Expense</b> <i>(Diagnostic &amp; Preventive)</i>	20%	20%	30%
<b>Type B Expense</b> <i>(Basic Restorative)</i>	40%	40%	55%
<b>Type C Expense</b> <i>(Major Restorative)</i>	50%	50%	65%
<b>Calendar Year Maximum</b>	\$2,000	\$2,000	\$2,000
<b>Orthodontic Treatment</b> <i>Coverage for Adults and Dependents</i>	50%	50%	60%
<b>Orthodontic Lifetime Maximum</b>	\$2,000	\$2,000	\$2,000
<i>Please refer to the Dental Plan Caveats below for additional benefit coverages for Types A, B and C</i>			
<i>Dental Plan Caveats</i>			

*Dental PPO*

*Type A*

*Includes Prophylaxis, Bitewing and full mouth series X-rays, Space Maintainers, Oral Exams, Fluoride applications, Sealants, and Periapical X-rays.*

*Type B*

*Includes Fillings, Simple Extractions and Oral Surgery.*

*Type C*

*Includes Crown Lengthening, Crown Buildup, Inlays/onlays, Bridgework, Osseous surgery, Soft tissue grafts, Partial and full bony impactions, General anesthesia and intravenous sedation, Dentures (benefit includes all relines, rebases and adjustments within 6 months of installation), Molar root canal therapy, Prosthetic repairs, and Occlusal Guards (for bruxism only).*

There are no other options for dental coverage at this time.

**12. How do employees request plan approval in their Swiss cantons? Do residents of France need to request approval?**

Members who are residents of Swiss cantons will need to request an approval form from their canton to be completed by Aetna International. Aetna will assign a team to help members transition into the new program. This team will complete the canton approval forms, which the member will then submit to their canton officials for approval. Contact information for the Aetna International team will be provided when available.

There is no such requirement for residents of France.

**13. Is there a local presence in Switzerland and France for the Aetna International program?**

No. There are International Service Centers located in Tampa, Florida, United States; Bangalore, India; Dubai, United Arab Emirates; and Manila, Philippines. In addition to these service center locations, Aetna has an international office in London, but this is an administrative office only.

**14. What hours are those phone lines available in Switzerland, France and the US?**

Support is available via the International Service Centers mentioned above, 24 hours a day, 7 days a week, and 365 days per year. Global claims processors, member service representatives, and International Health Advisory Team members are available to assist members with questions via a toll-free phone number, fax and e-mail.

**15. Is it possible to speak with the same person in customer service each time a person calls back?**

No, but all of Aetna's internal systems (billing, enrollment, financial, policy data entry, claims and pharmacy management) are integrated so that all staff, health concierges and clinical care managers have access to all the necessary information to assist you.

Aetna's online system creates a 360-degree view of each member for the customer service representative. The system stores members' eligibility data, benefit descriptions, provider contact information and files, prior contacts with Aetna, preferred methods of contact, referrals, disease management program activity history, disability event data and detailed claim history. The system gives all staff, health concierges and clinical care managers immediate information and the ability to monitor and resolve inquiries by tracking:

- Date and time of inquiry (opened and closed)
- Source (member, provider, other), name, method of contact
- Health concierge servicing the inquiry
- Reason(s) for the contact
- Status of inquiry
- Action taken

Should a member prefer one-on-one support with specific medical issues, International Health Advisory Teams (IHAT) are located in every service center worldwide. These teams are comprised of clinicians that support members in their region. Members can call or e-mail an IHAT Care Manager, 24 hours a day, 7 days a week, and 365 days per year, for care management services, including pre-trip planning, care management, coordination of emergency medical evacuation services and catastrophic care management.

**16. Are there any pre-existing condition clauses (delays or exclusions)?**

No, there are no pre-existing condition clauses.

**17. Is a pre-certification required for any medical and/or dental procedure (surgery, maternity, physical therapy)? If so, how does the member request pre-certification?**

Pre-certification is only required in the U.S. for certain types of Non-Preferred care received inside the U.S. and must be obtained to avoid a reduction in benefits paid for that care. No pre-certification is required for procedures occurring outside the U.S.

In the U.S., pre-certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required - excluded amounts apply separately to each type of expense. Members should contact the service center to determine if pre-certification is needed for a service.

Aetna pre-certifies to ensure medically appropriate care is delivered for high acuity or high cost medical events. Pre-certification criteria are based on evidence-based medicine and guidelines. In addition, strict criteria ensures Aetna's partnered facilities maintain high standards of quality. For example, Aetna designates certain bariatric surgical centers as Institutes of Quality (IOQ) based on outcome metrics. This ensures members receive the desired standard of care. Knowing about procedures in advance, and being able to direct members to facilities that meet Aetna's standards help deliver quality care and outcomes to members.

If you are undergoing treatment that requires pre-certification in the U.S., your in-network doctor will assist you in requesting the pre-certification.

**18. Is there coverage for in vitro fertilization and what is it? Are there limitations? Please describe the coverage and limits.**

Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.

The coverage is as follows:

PPO Medical			
PLAN FEATURES	Outside the U.S.		In the U.S.
			Preferred Benefits (In-Network)
Preventive Benefits			
Non-Preferred Benefits (Out-of-Network)			
<b>Base Infertility Services</b>  (Base plan coverage includes coverage limited to the testing and treatment of underlying condition)	No charge	No charge	30% after deductible
<b>Comprehensive Infertility Services</b> \$15,000 lifetime maximum  (Comprehensive plan coverage includes coverage for Artificial Insemination and Ovulation Induction)	No charge	No charge	30% after deductible
<b>ART Infertility Services</b> \$15,000 lifetime maximum  (Advanced Reproductive Technology (ART) coverage includes, but not limited to In vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT) treatments.	No charge	No charge	30% after deductible

**19. Does Aetna International provide any additional resources for members who are currently undergoing a course of treatment or receiving maternity care?**

An International Health Advisory Team (IHAT) comprised of regionally located doctors and nurses provides services 24 hours a day, 7 days a week, and 365 days per year. The IHAT helps members with their health care experiences by acting as the central point of contact throughout a health care event including events such as maternity.

Members expecting a new addition to the family experience changes in their health and health related needs. Aetna's maternity counseling program provides education and support to members when they need it most. Members receive customized clinical support from their dedicated IHAT, plus numerous health-related materials and tools.

## 20. Is there coverage for midwives (such as after or for the birth of a child)?

### Pregnancy Related Expenses

Covered expenses include charges made by a physician for pregnancy and childbirth services and supplies at the same level as any illness or injury. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, covered expenses include charges made by a Hospital for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a birthing center as described below.

### Birthing Center

A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.

Note: Covered expenses also include services and supplies provided for circumcision of the newborn during the stay.

## 21. What is covered for maternity leave and childbirth?

The following paragraphs explain what is covered under the maternity benefit:

Prenatal Visits, Delivery, Miscarriage and Antepartum (Prenatal) Care, genetic counseling, chromosome karyotyping and amniocentesis performed during the 16th to 18th week of pregnancy are medically necessary. Gestational diabetes screening is available as a preventive benefit for all plans and plan sponsors. Gestational diabetes screening is considered a preventive service.

If the plan has no cost share for preventive services, then there is no cost share for gestational diabetes. Otherwise, gestational diabetes screening follows the routine cost share based on the plan of benefits.

Routine prenatal or antepartum care includes:

- The initial and subsequent history
- Physical exams
  - Monthly visits up to 28 weeks gestation
  - Biweekly visits to 36 weeks gestation
  - Weekly visits until delivery
  - Post-partum visit (approximately 45 days after delivery)
- Recording of weight
- Blood pressures
- Fetal heart tones
- Routine chemical urinalysis

**The Affordable Care Act (ACA) provides for the following:**

Prenatal care and breastfeeding

You have no member cost sharing (copays, coinsurance or deductibles) for preventive prenatal visits provided by an in-network provider. Normal cost sharing applies for delivery, postpartum care, ultrasounds or other maternity procedures, specialist visits and certain lab tests. Even if the plan doesn't cover maternity care, it will cover the preventive prenatal visits.

Women who need support with breastfeeding can get up to six visits with a lactation consultant at no cost. In-network obstetrician/gynecologists (Ob/Gyns) and pediatricians may offer these services. You can also check your provider directory. Just log in to your secure member website at [www.aetna.com](http://www.aetna.com) or call the Member Services number on your Aetna ID card to find a lactation consultant in the network.

**Aetna also covers:**

- Certain standard electric breast pumps (nonhospital grade) anytime during pregnancy, after delivery or for as long as you breastfeed, once every three years
- Certain manual breast pumps anytime during pregnancy, after delivery or for as long as you breastfeed
- Another set of breast pump supplies, if you get pregnant again before you are eligible for a new pump
  - Before buying a pump, check out the details on the website. Go to [www.aetna.com](http://www.aetna.com) and search for "breast pumps." Or call Member Services to learn details of what is covered and find a participating breast pump supplier.

**22. Are vaccinations covered? What's covered and at what ages?**

The standard plan covers the following:

- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control
- Immunizations for infectious disease, but not if solely for your employment
- Testing for Tuberculosis



As a standard, Aetna International covers anti-malarial medication (identified as such on the claim) under the plan's prescription drug benefit. We cover charges at 100% of the billed amount for these Anti-Malaria medications, regardless if dispensed in or out of the United States. Charges are not subject to deductible or coinsurance.

### **Routine Physical Exams**

Covered expenses include charges made by your physician for routine physical exams. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

**Covered expenses** for children from birth to age 18 also include:

- An initial hospital checkup and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

### **23. Where can members go to get vaccinations (such as for a child)?**

Members are able to utilize a provider of their choice or a provider in Aetna's direct settlement network. Members can access direct settlement network providers via, [www.aetnainternational.com](http://www.aetnainternational.com), the secure member website.

### **24. When will plan information be available for employees?**

Plan documents, which provide details of coverage, are provided within 90 days after the benefits have been entered into Aetna's system. Members and clients have access to these documents via the secure website.