IDB
Inter-American
Development Bank

IIC
Inter-American
Investment Corporation
A Member of the IDB Group

ACTIVE AND RETIRED STAFF

INTERNATIONAL MEDICAL BENEFITS PROGRAM HANDBOOK

TABLE OF CONTENTS

ABOUT THIS HANDBOOK

This handbook provides information about the Inter-American Development Bank's ("The Bank")[1] Medical Benefits Program.

The program includes coverage for:

- Medical
- Prescription Drugs
- Vision
- Dental

The handbook explains each of these plans, section by section. It highlights what is covered, and everything you need to know about how your benefits work. It also provides useful information on who to contact if you need additional assistance.

Information boxes, marked with the symbol: i highlight key information about a topic.

A glossary of terms is available at the end of the handbook for reference.

All amounts presented in this handbook are in U.S. dollars.

1 This handbooks also applies to the Inter-American Investment Corporation (IIC)

SECTION 1

YOUR BENEFITS

SECTION 1. YOUR BENEFITS

1.1 BENEFITS AT A GLANCE

Each of the plans included in the Medical Benefits Program provides comprehensive coverage designed to protect you and your family.

The chart below provides a quick overview of the plans. You will find more details about each plan in later sections of this handbook.

Plan type	Benefits
Medical	Defined Benefits Plan. In the USA plan members have access to in and out-of-network benefits through a Preferred Provider Organization (PPO) network
	Covers doctor's office visits, emergency care, hospitalization, preventive care, and many other services
Prescription Drugs	Generic and brand-name prescriptions available at pharmacies nationwide, and through the mail
Vision	Covers a portion of the expense for eye exams, frames and lenses, and contact lenses
Dental	Covers the largest portion of the cost of preventive care, diagnostic care, and basic restorative care Additional benefits for major restorative care and for orthodontics
Retiree Death Benefit	Provides death benefits for eligible retirees and their spouses

1.2 NEW TO THE PROGRAM

During the first 30 days of coverage, if you incur eligible medical expenses you should pay at the time of service and submit your claims later. During this period you should also expect the arrival of your ID card. If you need support to find a medical provider, please contact your plan administrator.[1] Information on how to submit a claim is listed in Section 8, Filing a Claim.

1.3 MEDICAL BENEFITS PREMIUMS

The Bank will periodically set and publish premium amounts payable by the participants.

1.4 EMPLOYEE WELL-BEING AND HEALTH BENEFITS TEAM (EW&HB)

The EW&HB team of the Compensation, Benefits and HR Services Division, supports the Bank in the provision of coverage for medical, dental, pharmacy, vision, life and AD&D insurance and Long-Term Disability (LTD) benefits, to its plan members.

The EW&HB team manages the relationship with the plan administrators and life insurance provider that, in turn, provide administrative services associated with the members' use of the benefits.

You may contact the EW&HB team regarding any of the following matters:

- File LTD claims
- Designate beneficiaries under staff's life insurance policies
- File life insurance claims for staff and dependents
- Request guidance through an appeal process for denied claims

Website & E-mail

http://HRD/ (Intranet only)
HRD/INS@iadb.org
www.iadb.org/retirees

Phone

1-202-623-3137
1-202-623-3305 (fax)

Mail

IDB Insurance
1300 New York Avenue NW
Mail Stop E-0403
Washington DC, 20577

For further information about eligibility and claims, please contact your plan administrator. Contact information is available under the "Plan Administrators" section of this handbook.

In addition to providing services related to medical benefits, the EW&HB is also responsible for developing and maintaining programs and initiatives that support and encourage our staff to maintain a healthy lifestyle, which includes the following services:

Employee Assistance Program (EAP). 24/7 free, confidential advice, support and referrals to the Bank's staff, and eligible dependents in dealing with life stresses and inter-personal relationship issues including issues related to domestic abuse.

Health Services Center (HSC). Offers a variety of services to employees in headquarters and country offices. Services offered in headquarters only: nursing care, emergency care, medical exams, and lab services. Services offered in headquarters and country offices: case management, referrals, counseling & health education, and immunization.

Wellness Programs. Raise awareness and provide opportunities for taking action on specific health related matters: Health fair, ergonomic evaluations, and well-being related seminars and services.

1 Plan Administrator is an external company that provides administration services for the Bank's plans.

Facilities. Lactation room (headquarters and country offices as applicable) Quiet room and fitness center (headquarters).

1.5 CONTACTING THE IDB ABOUT A WORK-RELATED ILLNESS OR INJURY

If you are injured or become ill due to a work-related incident, you must inform the Bank immediately in order to receive the needed support and benefits.

Location & Time	Who to Notify	Phone
Headquarters during regular hours	Health Center Supervisor	202-623-3135
Headquarters during non-regular hours	Security guard on duty	202-623-3300
Country Office (COF)*	Representative	
Traveling on mission*	Mission Chief	

*During an official mission or if assigned to a COF, please notify the Representative or Mission Chief. He or she should provide a full written report of the incident to the EW&HB team within seven days.

1.6 PLANS ADMINISTRATION

The Bank hires external companies or third party administrators (TPAs) to process claims and assist with designing and implementing benefit updates, network access, and billing on behalf of the IDB. For life insurance, the Bank hires an insurance company to provide coverage under the terms of a policy. The Executive Secretariat of the Staff Retirement Plan (SRP) manages the retiree death benefit.

The assignation of the plan administrator depends on where the plan member resides. Regardless of where you receive medical care, your plan/claim administrator remains the same.

You location	Website & E-mail	Phone	Mail
If you reside in the United States your Plan administrator is CIGNA Healthcare	www.myCIGNA.com iadb@cigna.com	1-855-511-6371 Fax: 1-844-851-6241 24/7/365 Customer service in English and Spanish Vision: 1-877-478-7557 Home Delivery Pharmacy: 1-800-285-4812 1-855-511-6371	CIGNA Healthcare Medical: P.O. Box 188060 Chattanooga, TN 37422 Dental: P.O. Box 188037 Chattanooga, TN 37422 Pharmacy: P.O. Box 188053 Chattanooga, TN 37422 Vision: P.O. Box 997561 Sacramento, CA 95899

If you reside outside the United States your Plan administrator is CIGNA IGO	www.CIGNAhealthbenefits.com iadb.global@CIGNA.com	1-305 908 9171 1-202 623 5577 1-305-908 9211 Fax: 305-908-9093 24/7/365 Customer service in English and Spanish	CIGNA IGO Health Benefits P.O. Box 260790, Miami, FL 33126 Overnight Delivery: CIGNA International Health Services 701 Waterford Way 4th Floor, Suite #425 Miami, FL 33126

Please note:

• You can contact your plan administrator to know more about: 1) How your benefits work; 2) What is covered; 3) Benefits and member eligibility; 4) Finding a doctor or providers; and 5) Claims status / updates.

• You will need your ID number and account information when contacting your plan administrator. Contact information is also available on the back of your insurance ID card.

The plan administrators secure websites allow you to submit and view status of claims, access providers network directories and request ID cards. They also provide tools to assist you and your family with personal health and wellness.

1.7 ELIGIBILITY AND COVERAGE

For terms and conditions such as eligibility, pre-existing conditions, mandatory and voluntary participation, enrollment and termination of coverage, please refer to Staff Rule PE-375 and its Annexes 1 & 2.

SECTION 2

MEDICAL PLAN

SECTION 2. MEDICAL PLAN

The Medical Plan provides comprehensive medical benefits for you and your covered family members.

2.1 MEDICAL PLAN OVERVIEW

The Medical Plan provides a full range of health care benefits and covers:

- Doctor's office visits
- Routine and preventive care
- Inpatient hospital services
- Outpatient services at hospitals, doctors' offices and other facilities
- Emergency care
- Urgent care

In-network vs. Out-of-Network providers. The plan is called a Defined Benefits Plan. It provides both in-network through a Preferred Provider Organization (PPO). and out-of-network benefits. Each time you need medical care, you choose what level of benefits you want to receive. Your benefits are greater when you use PPO network providers. If you decide to use out-of-network providers, you are still covered under the Medical Plan. However, you will need to pay a deductible and a higher percentage of the cost. Generally, you pay more for out-of-network services.

2.1.1 CARE OUTSIDE THE UNITED STATES

If you receive medical attention outside the US your claims will be considered in-network. That means you will not need to pay a deductible and that the Plan will pay benefits at the higher, in-network level.

2.1.2 FINDING PPO PROVIDERS

Log on to your claims administrator's website where you will find up to date information on network hospitals, doctors, and other health care providers in your area.

2.1.3 IMPORTANT MEDICAL TERMS

To understand how the plan works, you should be familiar with a number of medical terms that you will see frequently in connection with your benefits. The complete list of medical terms is listed under the Section Glossary of Benefit Terms.

2.2 TABLE OF COVERED MEDICAL SERVICES

Lifetime Maximum	IN NETWORK Unlimited	OUT-OF-NETWORK Unlimited
Deductible (per calendar year)		
• Individual	None	$500
• Family maximum	None	$1,000
Family maximum calculation: Individual maximum - Family members must meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		
Out-of-Pocket Maximums (per calendar year)		
• Includes deductibles	Not applicable	Yes
• Individual maximum	$1,000	$2,000
• Family maximum	$2,000	$4,000
• Includes penalties for non-compliance with pre-certification	No	No

• Includes charges paid in excess of reasonable and customary ("R&C")	Not applicable	No
Family maximum calculation: Individual maximum - Family members must meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of- Pocket being met, their claims will be paid at 100%.		
	The Plan Will Pay	The Plan Will Pay
Doctor's Office Visits		
• For Illness	90%	80% of R&C, after deductible
• For Injury	See Emergency Care	See Emergency Care
Routine Preventive Care	100%	100% of R&C
• For all ages - Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care Benefit • For all ages - Immunizations (including cost of biologicals that are immunizations or medications for the purpose of travel)		
Surgery	100%	100% of R&C
Second Opinion for Surgery (includes Lab & X-ray)	100%	100% of R&C
Pre-admission Testing	100%	80% of R&C, after deductible
Inpatient Hospital Facility Services		
• Semi-private (SP) room	100% (of negotiated rate)	80% of R&C, after deductible
• Private room	100% (of SP negotiated rate)	80% of R&C, after deductible (up to SP rate limit)
• Intensive Care Unit (ICU)	100% (of negotiated rate)	80% of R&C, after deductible (up to ICU daily rate limit)
• Doctor's Visits/Consultations	90%	80% of R&C, after deductible
• Professional Services	100%	80% of R&C, after deductible
Outpatient Surgery		
• Facility services	100%	80% of R&C, after deductible
• Professional services	100%	80% of R&C, after deductible
Emergency Care		
• Includes ambulance services when medically necessary	100%	100% of R&C
• Hospital Emergency Room Visit	1 00% after $100 deductible. Deductible is waived if admitted	100% of R&C after $100 deductible. Deductible is waived if admitted
Lab & X-Ray Services		
• Outpatient at a hospital	100%	80% of R&C, after deductible
• At a lab and x-ray facility	90%	80% of R&C, after deductible
• At a doctor's office	90%	80% of R&C, after deductible
Outpatient Short-Term Rehabilitation		
• Medical necessity review required after 30 visits per calendar year, except acupuncture	90%	80% of R&C, after deductible
Kidney Dialysis	90%	80% of R&C, after deductible
Home Health Care/Registered Nurses		
• Up to 40 visits per calendar year	90%	80% of R&C, after deductible
Outpatient Private Duty Nursing	90%	80% of R&C, after deductible

	The Plan Will Pay	The Plan Will Pay
Hospice		
• Semi-private or private room	100%, (based on negotiated rate)	80% of R&C, after deductible (up to SP rate limit)
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• Inpatient facility	100%	80% of R&C, after deductible
• Semi-private (SP) room	Limited to SP negotiated rate	80% of R&C, after deductible (up to SP rate limit)
• Private room	Limited to SP negotiated rate	80% of R&C, after deductible (up to SP rate limit)
• Intensive care unit (ICU)	Limited to negotiated rate	80% of R&C, after deductible (up to ICU daily rate limit)
• Physician (surgical) services	100%	80% of R&C, after deductible
• Inpatient visits/consultations	90%	80% of R&C, after deductible
Durable Medical Equipment	90%	80% of R&C, after deductible
External Prosthetic Appliances	90%	80% of R&C, after deductible
Mental Health and Substance Abuse		
• Inpatient	100%	80% of R&C, after deductible
• Physician charges	80%	80% of R&C, after deductible
• Outpatient	80%	80% of R&C, after deductible
Maternity		
• Initial visit to determine pregnancy	90%	80% of R&C, after deductible
• Delivery (includes all subsequent prenatal and postnatal visits)	100%	80% of R&C, after deductible
• Hospital (includes birthing centers)	100%	80% of R&C, after deductible
Abortion (Includes elective or non-elective procedures for any eligible family member)		
• Office visits	90%	80% of R&C, after deductible
• Inpatient facility	100%	80% of R&C, after deductible
• Outpatient facility	100%	80% of R&C, after deductible
• Physician's (surgical) services	100%	80% of R&C, after deductible
Family Planning		
• Office visits (including tests and counseling)	90%	80% of R&C, after deductible
• Surgical sterilization procedures (for vasectomy /tubal ligation, including reversals of the same)	100%	80% of R&C, after deductible
Infertility Treatment. Lifetime maximum of $50,000		
• Office visits (including tests and counseling)	90%	80% of R&C, after deductible
• Surgical procedures for infertility (including AI, IVF, GIFT, ZIFT, etc.)	100%	80% of R&C, after deductible
Hearing Aid Benefit		
• Hearing evaluation or test, and any hearing aid(s) prescribed, including their repair.	80% Up to a maximum of $5,000 every five years	80% Up to a maximum of $5,000 every five years
First pair of glasses following a cataract surgery	80%	80%

2.3 COVERED MEDICAL SERVICES

- Routine Care Benefits. You and your covered dependents are eligible for routine care benefits (for example, immunizations, annual physicals, etc.).
- Ambulances. Charges for local ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided. Local ambulance service includes Medivac helicopters, as long as their use is medically warranted.
- Hospital bed, hospital board, services, and supplies. Charges made by a hospital for bed and board, and for other necessary services and supplies (subject to the limits shown in the schedule).
- Outpatient hospital medical care. Charges made by a hospital, for medical care and treatment provided on an outpatient basis.
- Surgical facility charges. Charges made by a freestanding surgical facility, for medical care and treatment.
- Outpatient mental health services. Charges made by a facility licensed to furnish mental health services, for care and treatment of mental illness provided on an outpatient basis.
- Outpatient treatment of alcohol and drug abuse. Charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.
- Physician and other fees. Charges made by a physician, a psychologist and other licensed health care professional services.
- Professional nursing services. Charges made by a nurse for professional nursing services.
- Anesthetics. Charges made for anesthetics and their administration.
- Lab tests. Charges for diagnostic X-ray and laboratory examinations.
- Radiation and other treatments. Charges for radium and radioactive isotope treatment, and chemotherapy.
- Blood. Charges for blood transfusions, and blood not donated or replaced.
- Gases. Charges for oxygen and other gases and their administration.
- Hearing Aid. Charges for hearing aids or examinations for prescription or fitting thereof.
- Equipment. Durable medical equipment may be purchased if it provides cost-effective alternative to rental. Your assigned claims administrator must approve all durable medical equipment purchases.
- Prosthetic devices. Replacements for a part of the body.
- Dressings and prescriptions. Charges for dressings, and drugs and medicines lawfully dispensed only upon the written prescription of a physician.
- Physical, occupational, or speech therapy. Charges for therapy provided by a licensed physical, occupational or speech therapist.
- Organ transplants. Charges made for or in connection with approved organ transplant services, including immune-suppressive medication; organ procurement cost and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other plan.
- Cataract surgery follow-up. Charges made for the purchase of the first pair of eyeglasses or contact lenses following cataract surgery.
- Home Health Care. Charges made by a home health care agency for the following medical services and supplies provided under the terms of a home health care plan for the person named in that plan:
    - Part-time or intermittent nursing care by or under the supervision of a registered graduate nurse.
    - Part-time or intermittent services of a

home health aide.
    - Physical, occupational, respiratory or speech therapy.
    - Medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a physician; and laboratory services; but only to the extent that such charges would have been considered covered expenses had a person required confinement in the hospital as a registered bed patient or confinement in a skilled nursing facility.
- Hospice care. Charges made due to terminal illness for the following hospice care services provided under a hospice care program:
    - By a certified hospice facility for bed and board and services and supplies, subject to the limitations shown in the schedule.
    - By a hospice facility for services provided on an out-patient basis.
    - By a physician for professional services.
    - For pain relief treatment, including drugs, medicines and medical supplies.

2.4 NON-COVERED SERVICES

Following is a list of non-covered services. If you have questions about whether the Medical Plan covers a particular service, contact your claims administrator.

The Medical Plan does not pay benefits for:

- Ambulance travel by airplane.
- Charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society or national authorities.
- Penalties imposed by any certification requirement shown in the coverage schedule.
- Charges made by a physician for or in connection with multiple surgeries that exceed the following maximum: when two or more surgical procedures are performed through the same surgical incision, the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and one-half the amount otherwise payable for all other surgical procedures.
- Charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts).
- Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder.
- Transsexual surgery and related services.
- Charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, such as the removal of calluses and corns or the trimming of nails, unless medically necessary.
- Charges for or in connection with cosmetic surgery, unless (a) a person receives an injury, while insured for these benefits, which results in bodily damage requiring the surgery; or (b) it qualifies as reconstructive surgery performed on a person following surgery; and both the surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed on any one of your dependents who is less than 16 years old to correct a congenital anomaly.
- Charges for a second surgical opinion rendered more than six months after a surgeon has first recommended the surgical procedure.
- Charges made for or in connection with the routine eye refractions, eye exercises, and for the surgical treatment for correction of refractive errors, including radial keratotomy,

when eyeglasses or contact lenses may be worn, except as provided for under the vision care plan in the schedule.

- Home Health Care. The following expenses for services of a home health care agency are not included as covered expenses:
    - Home health care visits in excess of 40 during a calendar year (each visit by an employee of a home health agency will be considered one home health visit, and each four hours of home health aide services will be considered one home health care visit).
    - Care or treatment that is not stated in the home health care plan; or
    - Any period when a person is not under the care of a physician.
    - Hospice Care. The following expenses for hospice care services are not included as covered expenses:
    - Any period when you or your dependent is not under the care of a physician.
    - Services or supplies not listed in the hospice care program.
    - Any curative or life-prolonging procedures
    - Services or supplies that are primarily to aid you or your dependent in daily living; or
    - To the extent that any other benefits are payable for those expenses under the coverage schedule .

For more information about exclusions that apply to the Medical Plan, see Section General Limitations and Exclusions.

2.5 GUARANTEE OF PAYMENT (GOP)

Outside the Unites States, the assigned plan administrator can and has mechanisms established to facilitate coordination of payment of hospitalization and surgery, by issuing a Guarantee of Payment. A GOP is a promise of payment issued by the medical plan administrator on behalf of the insured member before the medical service is rendered.

The GOP establishes the procedures/services to be rendered, the amounts to be paid and the service provider to receive payment. Members can begin the GOP request process prior to their scheduled hospitalization/surgery.

To process a GOP please contact your plan administrator

2.6 CASE MANAGEMENT

If you or one of your covered family members need medical treatment for a serious condition, the case management service offered by the plan administrator can help.

2.6.1 HOW IT CAN HELP

Case management is designed to make sure you get the right care in the right setting and to coordinate all the details of your treatment program when you or a family member is coping with a serious illness.

Deciding whether to participate in the case management is completely up to you, but it can provide help with finding the right resources and getting the right treatment when you and your family may need it most.

2.6.2 CASE MANAGEMENT COST

The claims administrator provides this service at no cost to you.

2.6.3 HOW TO USE THE SERVICE

You, one of your family members, or your doctor can start the process with a phone call to the plan administrator. Once they understand your

particular situation, you are assigned a Case Manager.

Case Managers are registered nurses who are supported by other health care professionals, each trained or with credentials in a clinical specialty area. Case Managers also receive support from a panel of physician advisors who provide input on up-to-date treatment programs and the latest medical technology.

Your Case Manager works with you, your family, and your doctor throughout your treatment, coordinating your care and making sure you have access to the services and support you need.

To get in touch with Case Management representatives, call the toll-free telephone number on the back of your Medical Plan ID card.

2.7 MEDICARE OVERVIEW

If you (or any of your covered dependents) are eligible for Medicare benefits because of age or any other reason, you should know about how Medicare works with the IDB Medical Plan. Participation in Medicare Part B is mandatory for the Bank's Plan.

Medicare is the hospital and medical insurance program sponsored by the U.S. Government. There are certain eligibility requirements for Medicare that you should know about. You are required to enroll if you are:

- A citizen or resident alien of the U.S.
- Qualified by age (65) and marriage.
- Qualified by residence;
- Eligible to participate for any other reason.

Medicare has two parts – Part A is for hospital insurance and Part B for medical insurance.

Part A helps pay for: care in hospitals, skilled nursing facilities, hospices, and for some home health care at no cost to you. To be eligible for Part A of Medicare, you (or your spouse) will need to have paid Medicare taxes for 10 years (or 40 "quarters"). If you meet this criteria, you are automatically enrolled for Part A coverage.

Part B helps pay for: doctors' charges, outpatient hospital care, and some other medical services that Part A doesn't cover. You are required to enroll in Part B of Medicare and pay the Part B premium, which will be reimburse by the IDB.

2.7.1 REIMBURSEMENT OF PART B PREMIUM

FOR NEW PARTICIPANTS

Once you receive your Medicare ID card showing enrollment in Medicare Part B, send a copy of that ID card EW&HB in order to receive reimbursement of the Medicare Part B premium.

FOR CURRENT PARTICIPANTS

If you are receiving a monthly Social Security payment from the U.S. government, your Medicare Part B premium is being deducted from that payment on a monthly basis. Upon receipt of your Medicare card copy, you will be reimbursed the current Medicare Part B premium on a monthly basis.

If you are not collecting Social Security, you will receive a quarterly invoice from Medicare. Submit a copy of that invoice to the following addresses and you will receive reimbursement of your Medicare Part B premium. The monthly equivalent will be paid to you each month.

Reimbursement procedure

To receive reimbursement you are required to send to P&A Group a copy of the letter from the Social Security Administration which indicates your

(current year) Medicare Part B monthly premium. You may send the copy of this letter by mail or fax to one of the following addresses:

Mail: The P&A Group
Flex Department
Attn: IDB Reimbursement Account
17 Court Street, Suite 500
Buffalo, NY 14202

Fax: Toll-free (855) 362-7711 (IDB participants' line)

The letter will be received by P&A Group and they will ensure the correct reimbursement of your premiums

P&A Group services:

P&A Group offers additional options and services related to the reimbursement process as follows:
Online account to manage and monitor your reimbursements
Online access to your account 24/7 at www.padmin.com
Access to Customer Service at 1(800) 688-2611 Monday to Friday from 8:30 am to 8:00 pm EST
Email account notifications on refund status and other information
Online refund premium request

2.7.2 WHERE TO FIND MORE INFORMATION

Remember that Medicare benefits are available only to those who meet the U.S. Government's eligibility criteria – turning age 65, for example. Other rules apply so check with the Social Security Administration at least three months before you turn 65 if you have questions about Medicare eligibility.

There's a toll-free number sponsored by the U.S. Government, 1-800-MEDICARE (1-800-633-4227). Once you are connected, you can initiate the enrollment process, order publications about Medicare, or hear pre-recorded information in English or Spanish. You can also access the Medicare website at http://www.medicare.gov.

2.7.3 COORDINATION WITH MEDICARE MEDICAL BENEFITS

If you are eligible for Medicare medical benefits, the IDB Medical Plan provides benefits after Medicare pays its share of your covered charges. Medicare will be the primary payer and IDB will be the secondary payer.

The IDB Medical Plan pays for 100% of the balance of allowed expenses left after Medicare pays the amount it covers. For eligible expenses that Medicare does not cover, the Medical Plan still provides 100% reimbursement.

Remember, though, that this level of reimbursement only applies to Medicare-eligible employees, retirees, and their Medicare-eligible covered dependents.

2.7.4 USING NON-PARTICIPATING MEDICARE PROVIDERS

Most doctors participate in the Medicare program. If you are Medicare-eligible but your doctor doesn't participate in the Medicare program, the IDB Medical Plan reimburses your eligible expenses as if you were not eligible for Medicare benefits. See table of covered medical services.

Providers who do not participate with Medicare must give IDB plan members a copy of their opt-out letter to certify that they are non-participation with Medicare Part B. CIGNA will need to see this letter before it can process your claim.

SECTION 3

PRESCRIPTION DRUG PLAN

SECTION 3. PRESCRIPTION DRUG PLAN

In the United States. The Prescription Drug Plan covers medications your doctor prescribes that requires: a) written prescription in the U.S, and (b) for medications that have been approved by the U.S. Food and Drug Administration. In this Section, you will see more about how the program works, and how you can keep your prescription costs low.

In other countries: no matter where you are, you are covered everywhere for prescription drugs plan. You simply purchase your medication and file a claim with your plan administrator.

3.1 HOW THE PRESCRIPTION DRUG PLAN WORKS

The Prescription Drug Plan includes coverage for brand-name and generic drugs. The Plan includes "mandatory generic substitution." This means that, when your prescription is available in both brand-name and generic drugs, the pharmacist will automatically dispense the generic drug. A generic drug is one that contains the same ingredients and provides the same therapeutic benefits as the higher-cost brand-name drug. Generic drugs enter the market once the patent of brand-name drugs expire.

The exception to this rule is when your doctor indicates on the prescription form that the pharmacist should dispense the prescription exactly as written. To do this, doctors often use the term, "DAW" or "dispense as written."

In the United States. When you get your prescriptions at a pharmacy that is part of your plan administrator's "network, all you need to do is show your Medical Plan ID card. You will be required to pay a "co-payment"; a fixed dollar amount you pay for your prescriptions.

If you are visiting the United States. You will find that most of the pharmacy chains are part of the plan administrator network. You can go to any pharmacy you wish; however, your costs are higher when you use a pharmacy that is not part of the network. The Plan Administrator Member Services can tell you which pharmacies are in the network. Please note all members, in the USA or abroad, receive a CIGNA prescription ID card.

While in the U.S., you must use your CIGNA Healthcare prescription card in order to be able to purchase medications in network pharmacies. In those pharmacies, you will only be required to pay the corresponding co-payment. For non-network pharmacies in the U.S. you will be required to pay the full cost then submit your claim to CIGNA Healthcare at iadb@cigna.com for reimbursement.

3.2 PURCHASING YOUR PRESCRIPTIONS BY MAIL ORDER

CIGNA Home Delivery Pharmacy (USA only) provides a mail order option when you have prescriptions for medications you need regularly to treat an ongoing condition (i.e., medications for diabetes, to prevent cardio-vascular disease, to lower cholesterol). When you use CIGNA Home Delivery Pharmacy, you will get a larger supply of maintenance medications with zero co-payment.

To use the mail order option, start by contacting CIGNA Home Delivery Pharmacy at 1-800-285-4812. CIGNA Home Delivery Pharmacy representatives will help you work through all the details. You can also log on to http://www. mycigna.com and follow the prompts for information about prescription by mail order.

If you are outside the U.S., the mail order option is not available because U.S. laws do not allow drug vendors to mail prescription drugs overseas.

At retail pharmacies, maintenance medications are dispensed for up to a 30-day supply. When you use the CIGNA Home Delivery Mail Order program, your prescription will dispense up to 3 times (90- day supply) in one fill.

3.3 PRESCRIPTION DRUG BENEFITS

In the USA		
Tier	Co-pay Retail 30-day supply	Co-pay Mail-order* 90-day supply
Generic	$5	$10
Formulary (preferred) Brand	$15	$30
Non-Formulary Brand	$30	$60
Specialty	$40	$80
Outside the USA		
Co-pay	$5	N/A
Lifestyle drugs (e.g. erectile dysfunction, impotence) • Limit of 4 pills per month		

* $0 mail order co-pay for generic and preferred brands, for preventive conditions only such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke, and prenatal nutrient deficiency

U.S. residents. If you are going to be traveling for extended periods of time and need more than a 90-day Rx supply, you can contact CIGNA Pharmacy and ask for a vacation override in order to get the necessary medication supply you need. CIGNA Pharmacy: 1-800-285-4812

3.4 WHAT IS NOT COVERED

The Prescription Drug Plan does not pay for:

- drugs or substances not approved by the U.S. Food and Drug Administration, or other national authority where your treatment occurs.
- Drugs labeled, "Caution – Limited by Federal Law to Investigational Use".
- Over-the-counter drugs.
- Prescription vitamins, except prenatal vitamins and certain vitamins that are part of cancer treatment.
- Herbal or food / nutritional supplements. Medicinal foods or medical vitamins.
- Any medicinal product which does not contain chemical ingridients. Pill/supplements, whose composition is made of natural ingredients, will not be covered regardless of how the is labeled in different countries.
- Homeopatic products, pill and medicines.
- Chinese medicine.
- Cosmetic prescriptions.
- Phytotherapy.
- Hair tonics and special shampoos.
- Special toothpastes.

SECTION 4

VISION PLAN

SECTION 4. VISION PLAN

The Vision Plan provides routine eye care benefits for you and your covered family members.

4.1 HOW THE VISION PLAN WORKS

To receive vision care benefits, you can go to the licensed provider of your choice. You and each of your covered dependents receive benefits for eye exams, new frames and lenses, and/ or contact lenses.

4.2 FREQUENCY OF YOUR BENEFITS

All your Vision Plan benefits apply for a 12 -month period. So, every 12 months, you will be covered for a new eye exam provided it is prescribed by your doctor. It works the same way for frames, lenses, and contact lenses. Once you receive a Vision Plan service, you will need to wait a calendar year before the plan will pay benefits for the same services again.

4.3 RECEIVING YOUR BENEFITS

The plan will pay benefits toward your total vision care cost after your visit to your eye doctor or optometrist. You submit your vision bills and any other pertinent receipts to the claims administrator for reimbursement.

For plan members outside the USA, the In-network maximums apply. The plan outside the USA reimburses plan members after they have incurred the medical expenses.

All plan members receive a CIGNA vision ID insurance card. Plan members residing outside the U.S. can use the vision ID cards while in the USA to obtain in-network benefits (co-pay applies). The CIGNA vision card will work similarly to the CIGNA Pharmacy card.

Please note vision cards are not personalized. When you, your spouse or children go to the eye doctor or eyewear store, simply present the card to the provider. Your vision care provider will then call to verify eligibility at 1-877-478-7557.

There is no deductible or coinsurance for the vision plan. Just submit your eligible expenses to receive your Vision Plan reimbursement. In the U.S., the plan administrator also has a network of eyewear providers who offer exams, eyewear and contacts at discount rates. The use of these providers will lower the amount not reimbursed by the vision benefit. Additional information and a provider directory can be found on the plan administrator website.

4.4 VISION BENEFITS

Benefit	In-network	Out-of-Network
Eye Exam	100% after US$10 copay	Up to 70% co-insurance
Single vision lenses	100% after $20 copay	Up to US$40
Bifocal lenses		Up to US$65
Trifocal/Progressive		Up to US$75
Lenticular lenses		Up to US$100
Contact lenses: Therapeutic	100% - no co-pay	Up to US$210
Contact lenses: Elective	US$250 allowance – no co-pay	Up to US$176
Frames*	US$250 allowance	Up to US$120
Laser eye surgery (Lasik)	20% discount	N/A
Frequency	Every 12 months	

* US$20 co-pay for frames only applies if new frames come withour a new prescription. If member pays US$20 co-pay for any type of prescription lenses, there is no additional co-pay for frames.

Please call 1-877-478-7557 if you have questions about eligibility, vision plan, benefits, and the provider network.

SECTION 5

DENTAL PLAN

SECTION 5. DENTAL PLAN

The Dental Plan covers you and your family members for routine preventive care, and for other services – including orthodontics – when you need them.

Normal dental care, provided the charges are reasonable and customary and do not exceed the amounts that would have been charged in the absence of insurance, are covered under the Dental Plan.

5.1 HOW THE DENTAL PLAN WORKS

To receive dental care benefits, you can go to the licensed provider of your choice.

5.1.1 USING IN AND OUT-OF-NETWORK PROVIDERS

In the U.S., the plan administrator offers a network of dentists who provide their services at discounted rates. If you use one of the plan administrator's network dentists, your out-of-pocket costs may be lower.

If you don't use network dentists, the Dental Plan still pays the same percentage of the cost for eligible charges.

For each type of covered service you need, the plan pays a percentage of the total cost, and you pay zero deductible.

5.2 TABLE OF COVERED DENTAL SERVICES

When you need	The Dental Plan pays	You pay:
Preventive and Diagnostic Care, such as: • Routine exams and cleanings (2 per year) • Full-mouth x-rays (every 2 years) • Bitewing x-rays • Panoramic x-rays (every 2 years) • Fluoride application (yearly for those under 19) • Sealants (yearly for under 19, posterior teeth only) • Space Maintainers (for non-orthodontic treatment only) • Emergency Care (for pain relief)	100%	0%
Basic Restorative Care, such as: • Fillings • Root canal therapy • Periodontal scaling and root planning • Denture adjustments and repairs • Extractions • Anesthetics	80%	20%
Major Restorative Care, such as: • Crowns • Dentures • Bridges	50%	50%

Oral Surgery, such as: • Surgical extractions • Frenectomy • Osseous surgery • Implants	100%	0%
Orthodontics	50% (up to US$2,500 lifetime maximum)	50%

Co-insurance amounts you pay for dental services do not count toward out-of-pocket maximum limits for the Medical Plan.

5.3 BENEFIT MAXIMUMS

For most covered services, your benefit maximum is an annual dollar limit of US$2,000 for staff in their first two years with the plan. Afterwards, the annual benefit maximum increases to US$4,000. This limit renews each calendar year.

For orthodontic benefits (like braces, for example), the benefit maximum is per lifetime. That means that the dollar limit does not renew each year.

5.4 PRE-DETERMINATION OF BENEFITS

When you and your dentist know that you'll need work that's more extensive than just routine care, it's a good idea to complete what CIGNA calls a "Pre-Determination of Benefits." This involves filling out a claim form before you get treatment. Doing this will let you and your dentist know in advance what the Dental Plan will pay.

On the CIGNA dental claim form, your dentist should include information about your upcoming treatment, then check the box labeled, "Pre-Determination of Benefits." Once CIGNA reviews the information, they'll let your dentist know what's covered and how much the Dental Plan will pay.

5.5 COVERAGE FOR ACCIDENTAL DAMAGE

If an accident or injury causes damage to your sound, natural teeth, you are covered for benefits, and the annual dental maximum does not apply.

5.6 WHEN SERVICES BEGIN

In all but a few cases, services begin when your dentist or someone working under his or her direction actually begins performing them. Here are the exceptions:

- Fixed bridgework, full dentures, or partial dentures: Service begins when the first impressions are taken and/or abutment teeth are fully prepared.
- Crowns, inlays, or onlays: Service begins on the first day of preparation of the affected tooth.
- Root canal therapy: Service begins when the pulp chamber of the tooth is opened.

These services fall into a different category because they often require other related services that are considered part of the same treatment.

5.7 WHAT IS NOT COVERED

The Dental Plan does not pay for:

- Experimental procedures or treatments that aren't approved by the American Dental Association, or by the national authorities in the country where you are, or by the dental specialty society.
- Services performed for cosmetic reasons only.
- Replacement of lost or stolen dental appliance.
- Replacement of a bridge, crown, or denture within five years after the date you originally receive it -- unless you need the replacement because the original is affected by (a) the placement of another (opposing) denture, (b) the extraction of natural teeth or (c) damage to the original as a result of an injury.
- Replacement of a bridge, crown or denture when the original can be repaired according to usual dental standards.
- Porcelain or acrylic veneers of crowns or pontics.
- Any services that don't meet the standard of usual dental practices.
- Any services that are covered by the Medical Plan.

SECTION 6

FILING A CLAIM

SECTION 6. FILING A CLAIM

6.1 MEDICAL/DENTAL PLANS

6.1.1 If you reside in the United States

and use the plan administrator's network's providers, you do not need to submit a claim because your provider will automatically submit it on your behalf. If you do not use a network provider or use providers outside the United states you will need to file a claim.

For most covered services, you will not be expected to make any payments to providers at the time you receive services. For any portion of your claim that the IDB Plan does not cover, you will receive a bill after the plan administrator has reimbursed the provider.

6.1.2 If you reside outside the United States,

you will need to file a claim. Claims should be submitted as soon as possible after the expense is incurred.

Please note:

No network provider should ask you to pay the full cost of services. If this happens, you should ask the provider to contact the plan administrator immediately. Occasionally, a provider may estimate a balance due and request that you pay it at the time you receive services. If this happens, make sure the provider's estimate of what you owe is based on the in-network rate the plan administrator has negotiated with the provider, as applicable.

6.2 PRESCRIPTION DRUG CLAIMS

6.2.1 If you reside in the United States

when you use the plan administrator's network pharmacies, you do not need to submit a claim.

When you use network pharmacies your only charge will be the copayment that applies to the medication you are purchasing. See the handbook section titled, "The Prescription Drug Plan" for more details about copayments.

There may be occasions when, due to travel, an emergency, or a special situation, you may have to use a non-network pharmacy. In these cases, you will need to file a paper claim with the plan administrator to receive reimbursement.

6.2.2 If you reside outside the United States

submit your claim as soon as possible after the expense is incurred.

For Headquarters Staff and Retirees in the United States. File with claims with your plan administrator CIGNA Healthcare, using the appropriate claim form, when you use out-of-network providers or when you use providers outside the United States.

For International Staff and Retirees Who Reside Outside the United States. Submit all reimbursement claims for Medical, Prescription Drugs, Vision, and Dental plan expenses to your assigned plan administrator CIGNA IGO, using the appropriate claim form.

Always use the I.D. number shown on your card, even though some forms ask you for your Social Security number. Keep copies of your claims and supporting documentation until you or the provider has received reimbursement.

6.3 DEADLINE FOR SUBMITTING CLAIMS IN A CALENDAR YEAR

You must submit any claims related to services provided during any calendar year no later than June 30 of the following year to qualify for payment of benefits. No exceptions.

6.4 EXPLANATION OF BENEFITS (EOBS)

For all services you will receive an Explanation of Benefits, or "EOB," statement from the claims administrator. Your EOB will show how the submitted charges affect your deductible (for out-of-network services), the portion of the submitted charges that were paid by the plan, and what portion (if any) is your responsibility.

6.5 SPECIAL PROVISIONS

6.5.1 PAYMENT TO MINORS

Reimbursement of expenses that apply to a person who is minor will be made directly to the minor's legal guardian.

6.5.2 IF YOU DIE BEFORE RECEIVING REIMBURSEMENT

In this case, the claims administrator may choose to make direct payment to your living relatives, including your spouse, mother, father, child(ren), brothers, or sisters. Payment may also go to the executors or administrators of your estate.

6.5.3 THE BANK'S LIABILITY

Payment as described above will release the Bank from all liability to the extent of any payment made.

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

SECTION 7. GENERAL LIMITATIONS AND EXCLUSIONS

The Medical Insurance Program includes coverage limits and exclusions for certain expenses. This section lists the general limits and exclusions that apply to the program.

7.1 WHAT THE PROGRAM DOES NOT COVER

The plans included in the Program do not cover:

- Services that aren't medically necessary - except preventive care services
- Unnecessary care, treatment, or surgery.
- Out-of-network medical plan charges in excess of reasonable and customary (R&C) amounts.
- Expenses that are unlawful in the locality where you live.
- Expenses that you are not legally required to pay.
- Expenses that wouldn't have been billed if you weren't covered under the IDB plans.
- Expenses billed by a hospital that's owned or operated by the U.S. Government – unless (a) there is a legal obligation to pay those expenses or (b) the expenses are related to treatment for illness or injury connected to military service.
- Expenses for custodial services, education, or training.
- Expenses that are eligible for reimbursement under a U.S.-sponsored public health program, or a similar type of program sponsored by another country. [Note that eligible programs include Medicare but not Medicaid].
- Over-the-counter medications or any other over-the-counter disposable or consumable supplies.
- Expenses submitted by any provider who is a member of your family, or the family of any of your covered dependents.

7.2 MEDICAL INSURANCE PROGRAM COVERAGE VS. AUTO INSURANCE COVERAGE

If you, or one of your covered family members, are injured in an automobile accident, you may be entitled to benefits coverage under certain provisions included in auto insurance policies. These provisions are included to comply with mandatory "no fault" insurance and uninsured motorist laws.

If any of these provisions apply to your situation, reimbursement for your medical expenses will come first from the auto insurance policy coverage.

7.3 SUBROGATION

If you are ill or injured through the fault of another person or organization, a third party (for example, an insurance company) might be liable or legally responsible for expenses incurred by you or your covered dependents. Benefits may also be payable under an IDB plan for such expenses.

In this situation, if a Bank's plan and a third party both pay expenses for you or one of your covered dependents, a process called "subrogation" will begin. Subrogation is a legal process that entitles the Bank's plan to recover payment it made for expenses that a third party was obligated to pay.

For purposes of the subrogation rules, a "third party" is defined as any person or organization – including their insurers – causing illness or injury to you or your covered dependents.

In its efforts to recover payment, the Bank may need you to provide any information and paperwork related to the expenses you incur because of the illness or injury caused by the third party.

7.4 COORDINATION OF BENEFITS

7.4.1 WHEN YOU HAVE OTHER INSURANCE COVERAGE

This section describes how the Bank's Medical, Dental, and Vision plans pay benefits if you (or one of your covered family members) have coverage through another group health plan.

When you are covered by the IDB plans and also by another outside plan or program – for example, the medical plan of your spouse's employer – the IDB plan will "coordinate" benefits with those other plans.

Coordination of benefits means that the benefits under one of the plans will be reduced so that the sum of the benefits payable from all plans Will not exceed more than 100% of the allowable expenses related to a particular claim.

7.4.2 PRIMARY AND SECONDARY BENEFITS

When two or more plans coordinate benefits, one plan pays first. To determine which plan pays first, the Bank relies on benefit determination rules. These rules establish the primary plan – which is the plan that pays first, and the secondary plan(s) – the plan(s) that pay only after the primary plan pays.

7.4.3 WHEN AN IDB PLAN IS PRIMARY

When the benefit determination rules indicate that the Bank's plan is primary, the Program will pay benefits as if there is no other secondary coverage.

7.4.4 WHEN AN IDB PLAN IS SECONDARY

When the benefit determination rules indicate that the Bank's plan is secondary, Bank's benefits will reduce so that the sum of the benefits payable under all plans (both primary and secondary) won't exceed 100% of allowable expenses.

7.4.5 BENEFIT DETERMINATION RULES

To establish the primary and secondary plans, the Bank follows standardized rules, which are:

- The plan that covers the claimant as a subscriber (or, in other words, not as a dependent) is primary, and any other plan that covers the claimant as a dependent is secondary
- The "Birthday Rule" – when a dependent is covered under an IDB plan and under another plan, the "birthday rule" determines the primary plan. The birthday rule says that the plan of the person whose birthday falls earliest in the calendar year is the primary plan

In certain cases, there are exceptions to this rule:

- If the other plan doesn't use the birthday rule, then that plan's alternate rule will determine the primary plan.
- If the claim is for a dependent child of divorced or separated parents, then the determination rules consider any court rulings that assign financial responsibility for benefits.

Court rulings

- For a dependent child of divorced or separated parents, any applicable court rulings will help determine the primary plan. If there is a court ruling that establishes financial responsibility for medical, dental, or other health care benefits, then the plan of the person named in the court ruling will be primary.
- The plan of a parent with custody will be primary and the plan of a step-parent will be secondary.
- The plan of a parent with custody will be primary and the plan of a parent without custody will be secondary.

Length of dependent coverage

- If the primary plan still has not been established, then the benefit determination rules consider how long the dependent with the claim has been covered under an IDB plan and how long the dependent has been covered by another plan. The plan that has covered the dependent for the longer period of time is the primary plan.

In certain cases there are exceptions to this rule:

- The plan of a working employee will be primary, and the plan of a person laid off, retired, or who's become a dependent of the working employee, will be secondary.
- If the other plan does not use the rule that makes the plan of the working employee primary and the plan of the laid off, retired, or dependent person secondary, then IDB will not use that rule. In such a case, if no other benefit determination rules are able to establish the primary plan, the primary plan will be established according to the length of time the dependent with the claim has been covered under an IDB plan compared to another plan.

The following definitions have special meaning in benefits coordination rules:

"Plan" means any of the following that provides medical, dental, or vision benefits or services;

- Group or blanket insurance coverage, other than group school accident policies
- Service plan contracts, group or individual practice or other pre-payment plans
- Coverage under any labor management trusteed plans;
- Union welfare plans
- Employer organization plans
- Employee benefit organization plans

"Plan" does not include coverage under individual or family policies or contracts. Each plan or part of a plan that has the right to coordinate benefits will be considered a separate plan;

- "Allowable Expense" means any necessary, reasonable, and customary term of expense that's covered, in full or in part, by any one of the plans that covers the person for whom the claim is made. When the benefits from a plan are in the form of services rather than cash payments, the reasonable cash value of each service is considered both an allowable expense and a benefit paid.
- "Allowable expense" does not include the difference between the cost of a private room and the cost of a semi-private room, except when the person's stay in a private room is considered medically necessary according to generally accepted medical practices.

SECTION 8

RETIREE DEATH BENEFIT PLAN

SECTION 8. RETIREE DEATH BENEFIT PLAN

The Executive Secretariat of the Staff Retirement Plan (SRP) manages the retiree death benefit.

When you retire from the Bank, you and your spouse are eligible for a retiree death benefit on the later of:

- The effective date of your pension; or
- The date your coverage ends under the basic group life insurance policy for active employees

The Retiree Death Benefit provides 2 coverage options: Basic Coverage and Supplemental Coverage.

- The Basic Coverage has no cost to the retiree and provides US$10,000 upon death of the retiree and US$5,000 upon death of the spouse.
- The Supplemental Coverage has a cost associated which depends on the age of the retiree on the date of his/her death and his/her final basic salary.

The Bank's Executive Secretariat of the Staff Retirement Plans (HRD/SRP administers this benefit. Please contact them to inquiry about eligibility, detailed information about coverage options and cost, designation of beneficiaries, filing claims, benefits payment, change of address, etc.

E-mail
VPF/SRP@iadb.org

Phone/Fax
1-202-623-3560
1-202-623-2177 (fax)

Mail
Executive Secretariat of the Staff Retirement Plan
Inter-American Development Bank
1300 New York Avenue NW
Mail Stop E507
Washington DC, 20577

SECTION 9

GLOSSARY OF BENEFIT TERMS

SECTION 9. GLOSSARY OF BENEFIT TERMS

Admitted. When the patient changes status from outpatient to inpatient.

Benefit Maximum. A dollar limit that an IDB plan will pay for covered services during a specified period of time.

Brand-name Drug. A drug still under patent by a specific pharmaceutical company.

Case Management. A free service the Claims Administrator provides, designed to ensure you receive the right medical care in the right setting when coping with a serious condition or illness.

Coinsurance. The portion (usually expressed as a percentage) of the total covered benefit costs that a plan pays (or that you pay).

Continued Stay Review. Process for ensuring that a continued U.S. hospital stay is the most effective setting for medical treatment. It takes place after you are admitted and focuses on whether additional days in the hospital are appropriate.

Conversion. A feature included in some of the IDB life and medical insurance plans, allowing you to switch your coverage to an individual policy if you leave the Bank. Different premium rates apply.

Coordination of Benefits ("COB"). When considering a claim for reimbursement of an eligible expense that is payable by an IDB plan and at least one other plan, the process of determining how much of the expense should be paid by IDB. Coordination of benefits ensures IDB will pay no more for such an expense than it would have had you been eligible for benefits under only the IDB plan.

Co-payment. The fixed amount you pay up front for prescription drug costs.

DAW. Short for "Dispense As Written," an abbreviation doctors sometimes use on prescription forms when they want the pharmacy to dispense medicine exactly as prescribed, with no generic or other drug substitutes.

Deductible. An annual amount you must pay for out-of-network services before the medical plan pays benefits for eligible expenses. As it related to the Medical Plan: If you are covering only yourself under the plan, your annual deductible is $200. If you are covering yourself and your family members, the annual deductible is $400. There is no deductible when you use PPO network providers.

Emergency Care. Medical services you receive at an Emergency Room or Urgent Care Center for accidental injuries or life threatening medical conditions.

Explanation of Benefits (EOB). A statement you receive from the plan administrator each time you receive Medical Plan services, showing how submitted charges affect your deductible (for out-of-network services), the portion of the submitted charges that were paid by the plan, and what portion (if any) is your responsibility.

Generic Drug. A drug that contains the same ingredients and provides the same therapeutic benefits as an equivalent, higher-cost brand-name drug. Generic drugs become available when brand-name drug patents expire.

Guarantee Issue Amount. The amount of coverage our life insurance carrier will provide without requiring proof of good health.

Home Health Care. Skilled nursing and other therapeutic services provided in a patient's home. Home health care can be a lower cost alternative to an extended stay in a hospital or skilled nursing facility.

Hospice. A health care facility or service providing

medical care and support services to terminally ill individuals and their families.

Mail Order. An option available in the U.S. for receiving prescription drugs through the mail. Mail Order prescriptions include up to a 90-day supply.

Medically Necessary. or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
a) in accordance with the generally accepted standards of medical practice;
b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
c) not primarily for the convenience of the patient, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. It is important to understand that even if you have a benefit for a particular service, if you do not have a medical need for that benefit, it will not be covered by the health plan.

Medicare. The hospital and medical insurance program sponsored by the U.S. Government.

Network. A group of hospitals, doctors, and other health care professionals that provide medical care at discounted rates.

Out-of-Pocket Maximum. An annual individual or family limit on the amount you spend out of your own pocket for medical plan expenses that the plan doesn't cover in full. If you cover only yourself under the Medical Plan, there in an individual maximum that applies to you only. If you are covering yourself and your family members, there is a maximum that applies to all of you. If your eligible expenses exceed these maximums, the plan will pay 100% of the cost for any additional eligible Medical Plan expenses for the rest of the calendar year, except for service specific maximums.

Over-the-Counter ("OTC") Drug. A medicine that is available for purchase without requiring a prescription from a doctor. Over-the-counter drugs are not covered under the IDB Medical Plan.

PPO. Short for "Preferred Provider Organization," an organization that contracts with a network of doctors, hospitals and other health care providers who deliver services for set fees, usually at a discount. PPOs offer both in-network and out-of-network benefits. You may use any licensed medical provider you like, but your benefits are highest (and your out-of-pocket costs lower) when you use network providers.

Pre-Admission Certification. The review and approval process the plan administrator conducts before you enter the hospital for treatment. Your doctor, you, or anyone close to you can start the process by notifying the plan administrator. Financial penalties apply for failure to notify the plan administrator.

Pre-Admission Testing. Tests your doctor may want to do before you enter the hospital.

Pre-Existing Condition. Any diagnosed illness, injury, or other condition that you received treatment for before being covered by the IDB Medical Plan.

Prior Creditable Coverage. A period of time when you were covered for a pre-existing condition under another health plan that reduces the pre-existing waiting period under the IDB medical plan.

Reasonable and Customary (R&C). The average prevailing cost in a particular geographic area for

medical plan services. Insurance companies submit claim data to the Health Insurance Association of America. They in turn tabulate the cost of each medical procedure in every generalized zip code area. Our plan then uses the 90th percentile as the R&C limit. This means that 90% of the providers in the generalized zip code area charge the R&C limit or less.

Routine Preventive Care. Regular medical plan benefits that you receive on a non-emergency basis for the maintenance of your good health.

Service-Specific Maximums. Specific dollar maximums that apply for certain medical plan benefits.

Subrogation. A legal process that entitles IDB to recover payment it made for medical plan or long-term disability plan expenses that a third party was obligated to pay.

Waiver of Premium. The discontinuation of premium payment for life insurance in the event you become totally disabled.

ACTIVE AND RETIRED STAFF

INTERNATIONAL
MEDICAL BENEFITS PROGRAM HANDBOOK