PROGRAM HANDBOOK OF MEDICAL BENEFITS

INTERNATIONAL

IDB | IDB Invest

January 2019

ACTIVE AND RETIRED STAFF

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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 how your benefits work. It also provides useful information on who to contact if you need additional assistance. Actual benefits will be issued in accordance with policy provisions, which may vary depending on the nature of the illness and/or type of service rendered.

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 handbook also applies to IDB Invest.

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	Indemnity Health Plan. In the US, 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	Covers prescription drugs worldwide
Vision	Covers a portion of the expense for eye exams, frames and lenses, and contact lenses
Dental	Covers a portion of the cost of preventive care, diagnostic care, and basic restorative care Additional benefits for major restorative care and for orthodontics

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.

The administrators are external companies that provide administration services for the Bank's plans: AETNA INTERNATIONAL administers the medical, dental and vision services inside and outside the USA. EXPRESS SCRIPTS administers prescription drug services in the USA and Puerto Rico, while AETNA INTERNATIONAL outside of the US. and Puerto Rico. Information on how to file a claim for medical, dental and vision services with AETNA INTERNATIONAL is presented in section 6: Reimbursement Request.

1.3 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 accidental death & dismemberment (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
1-202-623-3090

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 team 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 retirees, 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.

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.

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*	Representative	
Traveling on official mission*	Mission Chief	

*During an official mission or if assigned to a Country Office, 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 administrator of your plan, especially in the case of pharmacy benefits, will depend of the place where the staff or retired member officially resides. In all cases, medical, dental, and vision benefits will be administered by AETNA INTERNATIONAL. This company will also administer the pharmacy benefits outside the US and Puerto Rico. The pharmacy benefits for staff and retired members that officially reside in the US, or for staff and retired members that officially reside outside of the US but travel to the US and Puerto Rico, will be administered by EXPRESS SCRIPTS INTERNATIONAL.

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.

Your location	Website & E-mail	Phone	Mail
If your official residence registered with the Bank is in the United States, the plan administrator for medical, dental, and vision benefits is AETNA INTERNATIONAL	Medical: www.aetnainternational.com iadbservice@aetna.com Dental: www.aetna.com Vision: www.aetnavision.com/www.eyemedvisioncare.com	Medical and dental: 1-888-633-1055 Fax: 1-859-425-3363 Vision: 1-877-973-3238 24/7/365 Customer service in English and Spanish	Medical: AETNA INTERNATIONAL P.O. Box 981543, El Paso, TX, 79998-1543 Dental: AETNA PO Box 14094 Lexington, KY 40521-4094 Vision: EMVC PO Box 8504, Mason, OH 45040-7111
If your official residence registered with the Bank is in the United States, the plan administrator for pharmacy benefits is EXPRESS SCRIPTS INTERNATIONAL	www.express-scripts.com	1-855-521-0824 Fax: 1-608-741-5475 24/7/365 Customer service in English and Spanish	EXPRESS SCRIPTS Home Delivery Service P.O. Box 66566 St. Louis, MO 63166-6566

Your location	Website & E-mail	Phone	Mail
If your official residence registered with the Bank is in the United States, and you travel abroad, the plan administrator for medical, dental, vision, and prescription drugs benefits is AETNA INTERNATIONAL	www.aetnainternational.com iadbservice@aetna.com	1-888-633-1055 Fax: 1-859-425-3363 24/7/365 Customer service in English and Spanish	AETNA INTERNATIONAL P.O. Box 981543, El Paso, TX 79998-1543
If your official residence registered with the Bank is outside of the United States, the plan administrator for medical, dental, vision, and prescription drugs benefits is AETNA INTERNATIONAL	www.aetnainternational.com iadbservice@aetna.com	1-888-633-1055 Fax: 1-859-425-3363 24/7/365 Customer service in English and Spanish	AETNA INTERNATIONAL P.O. Box 981543, El Paso, TX 79998-1543

Your location	Website & E-mail	Phone	Mail
If your official residence registered with the Bank is outside of the United States, and you travel to a country other than the United States, the plan administrator for medical, dental, vision, and prescription drugs benefits is AETNA INTERNATIONAL	www.aetnainternational.com iadbservice@aetna.com	1-888-633-1055 Fax: 1-859-425-3363 24/7/365 Customer service in English and Spanish	AETNA INTERNATIONAL P.O. Box 981543, El Paso, TX, 79998-1543
If your official residence registered with the Bank is outside of the United States, and you travel to the United States, the plan administrator for medical, dental, and vision benefits is AETNA INTERNATIONAL	Medical: www.aetnainternational.com iadbservice@aetna.com Dental: www.aetna.com Vision: www.aetnavision.com / www.eyemedvisioncare.com	Medical and dental: 1-888-633-1055 Fax: 1-859-425-3363 24/7/365 Customer service in English and Spanish Vision: 1-877-973-3238 24/7/365 Customer service in English and Spanish	Medical: AETNA INTERNATIONAL P.O. Box 981543, El Paso, TX, 79998-1543 Dental: AETNA PO Box 14094 Lexington, KY 40521-4094 Vision: EMVC PO Box 8504, Mason, OH 45040-7111

Your location	Website & E-mail	Phone	Mail
If your official residence registered with the Bank is outside of the United States, and you travel to the United States and Puerto Rico, the plan administrator for the prescription drugs benefits is EXPRESS SCRIPTS	www.express-scripts.com	1-855-521-0824 Fax: 1-608-741-5475 24/7/365 Customer service in English and Spanish	EXPRESS SCRIPTS Home Delivery Service P.O. Box 66566 St. Louis, MO 63166-6566

1.7 ELIGIBILITY AND COVERAGE

For terms and conditions such as eligibility, pre-existing conditions (applicable to dependent parents only), mandatory and voluntary participation, enrollment and termination of coverage, please refer to Staff Rule PE-375 and its Annexes 1 & 2 (See Annex on Staff Rule PE-375).

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

The plan is called a Indemnity Health Plan and it reimburses you after you have incurred the medical expenses and have filed a claim with your plan administrator.

Submit your reimbursement requests through the different channels offered by AETNA INTERNATIONAL.

If you need medical services in the US, you have access to AETNA INTERNATIONAL'S network and could benefit from the discounted rates offered by the network providers who are part of its Preferred Provider Organization (PPO).

If you decide to use out-of-network providers in the US, you're still covered under the Medical Plan, but you'll receive the benefits at a higher co payment at Reasonable and Customary rates. 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

Call AETNA INTERNATIONAL or EXPRESS SCRIPTS or log on to their websites to find up to date information on network hospitals, doctors, and other health care providers in your area. Contact information in section 1.6.

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 9 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%.

	IN NETWORK The Plan Will Pay	OUT-OF-NETWORK The Plan Will Pay
Doctor's Office Visits		
• For Illness	90%	80% of Reasonable & Customary* (R&C), after deductible
• For Injury	See First Aid**	See First Aid**
Routine Preventive Care	100%	100% of R&C, after deductible
• 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)		
Mental Health and Substance Abuse		
• Inpatient	100%	80% of R&C, after deductible
• Outpatient - Physician's Office	90%	80% of R&C, after deductible
• Outpatient - All other Services	100%	80% of R&C, after deductible
Surgery	100%	80% of R&C, after deductible
Second Opinion for Surgery (includes Lab & X-ray)	100%	100% of R&C, after deductible
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

	IN NETWORK The Plan Will Pay	OUT-OF-NETWORK The Plan Will Pay
Outpatient Surgery		
• Facility services	100%	80% of R&C, after deductible
• Professional services	100%	80% of R&C, after deductible
Urgent Care	100%	100% of R&C
Emergency Care		
• Includes ambulance services when medically necessary	100%	100% of R&C
• Hospital Emergency Room Visit	100% 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	90%	80% of R&C, after deductible
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

	IN NETWORK The Plan Will Pay	OUT-OF-NETWORK The Plan Will Pay
Hospice		
• Hospice, semi-private room	100%, (based on negotiated rate)	80% of R&C, after deductible (up to SP rate limit)
• Hospice, 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	100% Limited to SP negotiated rate	80% of R&C, after deductible (up to SP rate limit)
• Private room	100% Limited to SP negotiated rate	80% of R&C, after deductible (up to SP rate limit)
• Intensive care unit (ICU)	100% 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
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

	IN NETWORK The Plan Will Pay	OUT-OF-NETWORK The Plan Will Pay
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 - Split $30,000 Medical Services, $20,000 Prescription Drugs.		
• 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
Vision		
• First pair of glasses following a cataract surgery	80%	80% of R&C, after deductible

*See section 10: Glosary of Benefit Terms
**First Aid: Resulting from accidental injuries, within 72 hours after an accident.

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 services are for emergency medical needs only and to the nearest hospital where medical care and treatment can be provided. Local ambulance service may include Medivac helicopters but only if their use is for emergency medical care, and it is 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 licenced facility for care and treatment of mental illness 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 medically warranted 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

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 U.S. Food & Drug Administration (FDA) or the appropriate medical specialty society or national authorities.
- 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 unless medically warranted (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.
- Charges related to chemical peels of any type, dermabrasion, intense pulsed light (IPL) and laser therapy (e.g. pulsed dye).

For more information about exclusions that apply to the Medical Plan, see Section 7 General Limitations and Exclusions.

2.5 LETTER OF AUTHORIZATION (LOA)

Outside the United States, AETNA INTERNATIONAL has established a process to issue a Letter of Authorization (LOA) for any non-network provider or hospital so you may receive necessary services without the need to pay up front and file a claim. Plan members may request a LOA in order to establish arrangements for AETNA INTERNATIONAL to pay for services.

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

Although many AETNA INTERNATIONAL network providers may not require a LOA, it is always a good idea to request a LOA in advance of scheduled services, and especially if there is uncertainty as to whether the provider is in- or -out-of-network for AETNA INTERNATIONAL.

In principle, a LOA should be granted by AETNA INTERNATIONAL within 72 hours after the request has been made, except in cases of emergencies in which a LOA should be issued almost immediately.

To process a LOA please contact AETNA INTERNATIONAL

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

Participation in Medicare Part B is mandatory for the Bank's Plan.

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. In principle, 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.

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 reimbursed 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 to 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 addresses found in the following sub-section 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 do not participate. AETNA INTERNATIONAL will need to see this letter before it can process your claim. We recommend submitting the letter with your claim reimbursement request to avoid delays.

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. You simply purchase your medication and file a claim with AETNA INTERNATIONAL.

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. If you request a brand drug when a generic equivalent is available, your prescription costs will be higher. You will pay the generic copay plus the difference in costs between the band name and the generic drug.

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 and Puerto Rico, 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 Prescription Drug Plan ID card from EXPRESS SCRIPTS. 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 or Puerto Rico, 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 an EXPRESS SCRIPTS drug prescription ID card.

While in the United States or Puerto Rico, you must use your EXPRESS SCRIPTS ID 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 United States, you will be required to pay the full cost and then submit your claim to EXPRESS SCRIPTS for reimbursement.

3.2 PURCHASING YOUR PRESCRIPTIONS BY MAIL ORDER

EXPRESS SCRIPTS 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 EXPRESS SCRIPTS Home Delivery Pharmacy, you will get a larger supply of maintenance medications (up to 90 days).

To use the mail order option, start by contacting EXPRESS SCRIPTS Home Delivery Pharmacy at 1-855-521-0824. EXPRESS SCRIPTS Home Delivery Pharmacy representatives will help you work

through all the details. You can also log on to http://www. express-scripts.com and follow the prompts for information about prescription by mail order.

If you are outside the United States or Puerto Rico, 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 90-day supply. When you use the EXPRESS SCRIPTS Home Delivery Mail Order program, your prescription will also be dispensed for up to 90-day supply in one fill.

The earliest you can request a refill is when 75% of the medication on hand is used (e.g., for a 90-day prescription, refills can be processed after 68 days). If you use Home Delivery (i.e. Mail Order) you can request a refill after 70% of your medication on hand is used (e.g. for a 90-day prescription, refills can be processed after 63 days).

3.3 PRESCRIPTION DRUG BENEFITS

In the USA and Puerto Rico	Co-pay Retail 30-day supply	Co-pay Mail-order* 90-day supply
Tier Co-pay		
Generic	$5	$10
Formulary (preferred) Brand	$15	$30
Non-Formulary (non-preferred) Brand	$30	$60
Specialty	$40	$80

* $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, cavities, colonoscopy, smoking cessation, malaria, obesity, and prenatal nutrient deficiency.

Lifetime maximum for Infertility drugs will be $20,000.

Lifestyle drugs (e.g. erectile dysfunction, impotence): Limit of 4 pills per month.

Outside the USA	Co-pay Retail 30-day supply	Co-pay Mail-order* 90-day supply
Co-pay	$5	N/A

Lifetime maximum for Infertility drugs will be $20,000.

Lifestyle drugs (e.g. erectile dysfunction, impotence): Limit of 4 pills per month.

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 EXPRESS SCRIPTS and ask for a vacation override in order to get the necessary medication supply you need. EXPRESS SCRIPTS: 1-855-521-0824

3.4 WHAT IS NOT COVERED

The Prescription Drug Plan does not pay for:

- Experimental drugs or substances not approved by the U.S. Food & Administration (FDA), 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 vitamins available over the counter.
- Any medicinal product which does not contain chemical ingredients. Pill/supplements, whose composition is made of natural ingredients, will not be covered regardless of how it is labeled in different countries.
- Homeopathic products, pill and medicines.
- Chinese medicine.
- Cosmetic prescriptions.
- Phytotherapy.
- Hair growth stimulants, 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 they are prescribed by your doctor. It works the same way for frames, lenses, and contact lenses, provided they are prescribed by your doctor.

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.

Some Vision care conditions are covered as medical services. The most common types are cataracts, glaucoma, conjunctivitis (pink eye). Injuries to the eye are also covered under medical services. For more information please contact AETNA INTERNATIONAL.

In the USA, in and out of network maximums apply for vision care and materials, as reflected in the second and third column of Table 4.4 below. Outside of the USA, in-network maximums apply for vision care and materials, as reflected in the second column of Table 4.4 respectively.

All plan members receive a AETNA Vision Preferred ID 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 AETNA Vision Preferred card will work similarly to the EXPRESS SCRIPTS card.

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. Additional information and a provider directory can be found on the plan administrator website.

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 to AETNA VISION at 1-877-977-3238.

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
Frequency**	Every 12 months	

* US$20 co-pay for frames only applies if new frames come without a new prescription. If member pays US$20 co-pay for any type of prescription lenses, there is no additional co-pay for frames.
** The 12-month frequency period begins on January 1st (calendar year basis).
One pair of contact lenses or a single purchase of a supply of contact lenses - on top of lenses and framed benefits, (In other words, you may receive contact lenses and frames in same benefit year).

Please call 1-888-633-1055 if you have questions about eligibility, vision plan, benefits, and the provider network. Also, please visit AETNA INTERNATIONAL'S website or download its app. if you need assistance to find in-network providers in the U.S.A.

SECTION 5

DENTAL PLAN

SECTION 5. DENTAL PLAN

The Dental Plan covers routine preventive care, and other services including orthodontics.

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.

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	**80%**	**20%**

When you need	The Dental Plan pays	You pay:
Major Restorative Care, such as: • Crowns • Dentures • Bridges	**50%**	**50%**
Oral Surgery, such as: • Surgical extractions • Frenectomy • Osseous surgery • Implants* • Anesthetics	**100%**	**0%**
Orthodontics	**50% (up to US$2,500 lifetime maximum)**	**50%**

* Implants for abutments are covered at 100% while the final piece, the implant crown, is covered at 50% by the Plan.

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 covered services, except orthodontics, 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 your dentist identifies that you'll need work that's more extensive than just routine care, it is advisable to request a pre-determination of benefits from the plan administrator to determine coverage and costs.

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 other dental professional 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.

Some Dental services such as those related to an accident are covered as medical services. For more information please contact AETNA INTERNATIONAL.

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 AND VISION CLAIMS

6.1.1 FOR US RESIDENTS

If you use AETNA INTERNATIONAL 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.

You can submit the claim through the Aetna International website, by mail, fax, email, or mobile app.

Detailed information about co-payments, coinsurances and benefit maximums for each plan is described in their respective sections.

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.

6.1.2 FOR NON-US RESIDENTS

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

6.2 PRESCRIPTION DRUG CLAIMS

6.2.1 FOR US RESIDENTS

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.

If you use an out-of-network pharmacy due to travel to another country, an emergency, or a special situation, submit your claim reimbursement request to your plan administrator.

6.2.2 FOR NON-US RESIDENTS

You will pay for the prescription and submit your claim reimbursement with Aetna International.

You will be reimbursed for the cost of the prescription minus the $5.00 co-pay applicable to overseas prescriptions.

Always use the ID 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 have received the corresponding refund.

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 (EOB)

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.

If you have questions on your EOB, please call AETNA INTERNATIONAL's service center at 1-888-633-1055. You may also view your EOB information online under 'My Claims' by logging in to your personal account at www.aetnainternational.com.

6.5 SPECIAL PROVISIONS

6.5.1 PAYMENT TO MINORS

Reimbursement of expenses that apply to a person who is a 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./Local 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 related to activities of daily living (ADLs): 1) Personal hygiene - bathing, grooming and oral care; 2) Dressing - the ability to make appropriate clothing decisions and physically dress oneself; 3) Eating - the ability to feed oneself though not necessarily to prepare food; 4) Maintaining continence - both the mental and physical ability to use a restroom; and 5) Transferring - moving oneself from seated to standing and get in and out of bed.
- 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

MISREPRESENTATION, FRAUDULENT CLAIMS, AND RECOVERY OF OVERPAYMENT

SECTION 8. MISREPRESENTATION, FRAUDULENT CLAIMS, AND RECOVERY OF OVERPAYMENT

8.1. MISREPRESENTATION AND FRAUDULENT CLAIMS

Members must notify the Bank of any changes affecting the eligibility of their dependents or themselves for participation in the Medical Benefits Program.

Members are also expected to submit claims consistently with the rules and procedures applicable to the Program and to be truthful in their dealings with the Bank and with the Program Administrator. Members must also cooperate with any audit, investigation or other inquiry regarding their participation and/or the participation of their dependents in the Program.

Any corrupt practice, misrepresentation, falsification of claims, other fraud, failure to cooperate with an investigation or other obstruction of an investigation, or any other wrongdoing related to participation in the Program shall be considered serious misconduct. The consequences of such misconduct may include, but shall not be limited to loss of eligibility to continue participation in the Program; the offset of other payments, including in the form of payments from the Program or other payments due from the Bank, to compensate the Program for wrongfully-paid amounts; and other process for the restitution to the Program or the Bank, as applicable, for lost amounts. Furthermore, the consequences of misconduct for active staff include disciplinary sanctions and may include the termination of employment.

The Bank may also refer any suspected violation of national law to the appropriate authorities.

8.2. RECOVERY OF OVERPAYMENT

Members must report overpayments immediately. In the event of overpayment, the Bank or AETNA INTERNATIONAL shall have the right to request repayment upon notification by the Bank or AETNA INTERNATIONAL to the plan member.

Failure to promptly repay such amounts shall be considered misconduct.

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. There is no deductible when you use in-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.

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). Reasonable and Customary (R&C). The prevailing cost for a specific medical plan service within a given geographical area of the United States. For purposes of our plan, for professional services, R&C is determined by using the 90th percentile of the costs established in nationally recognized databases utilized by third-party administrators and insurers as the acceptable rate of payment (i.e. limit). This means that, for a specific service, 90% of the providers in the geographic area charge the same or less than the R&C rate. R&C for all other services (including services at out-patient surgical or specialized facilities, lab & X-ray services, external prosthetic appliances, durable medical equipment, etc.) is set at 300% of Medicare rates. Outside the United

States, the R&C for each country is determined by the administrator based on prevailing costs within that country.

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.

ANNEX: REGULATIONS

PE-375 MEDICAL INSURANCE PROGRAM

INTRODUCTION

The purpose of this Staff Rule is to regulate the participation in the Medical Insurance Program provided by the Bank.

INTERPRETATION AND APPLICATION

The Vice President for Finance and Administration shall be responsible for the determination of issues that may arise regarding the interpretation of this Staff Rule and its Annexes, consistent with the principles established herein, and the General Manager of the Human Resources Department shall be responsible for their application.

AUTHORITY

The Vice-President for Finance and Administration, following existing policies, shall be responsible for proposing, for consideration of the President of the Bank, any substantial modifications to the Medical Insurance Program, including premiums and terms of coverage. Non-substantial changes shall be informed to the Office of the Presidency prior to the approval by the Vice-President for Finance and Administration of such measures.

1. GENERAL

1.1. The terms of coverage under the Medical Insurance Program will be published by the Bank.

1.2. The Bank will periodically set and publish premium amounts.

1.3. The Medical Insurance Program is a Bank benefit for which eligible participants pay a premium in the amounts approved by the Bank.

1.4. Premiums paid by the participants will be deducted from their salary or pension, as applicable.

1.5. When both spouses are Bank staff and/or former staff and both participate in the family Medical Insurance Program, only one premium payment for said family will be deducted which will be from the spouse with the higher premium.

2. DEFINITIONS

2.1. For purposes of this Staff Rule, the following applies:

2.1.1. Medical Insurance Program ("Program"): Health plan sponsored by the Bank which includes medical, dental, vision, and pharmacy benefits. The Program is also referred to as Retiree Medical Insurance Program.

2.1.2. Parent Medical Coverage: Coverage under the Bank's Medical Insurance Program provided to the participant's eligible dependent parent.

2.1.3. Participant: A staff member or retiree enrolled in the Medical Insurance Program.

2.1.4. Retiree: Former active staff member participating in the Medical Insurance Program, who has been retired under the Bank's Retirement Plans on a pension, whether immediate or deferred.

2.1.5. Spouse: The person registered with the Bank as the wife or husband; or the domestic partner of the participant as per Staff Rule PE-360 "Staff and Family Relationships."

2.1.6. Dependent Children: Children of the participant or the spouse of the participant as established in Staff Rule PE-360 "Staff and Family Relationships".

2.1.7. Dependent Parent: Parent or parent-in-law of the participant as established in Staff Rule PE-360 "Staff and Family Relationships".

2.1.8. Dependents: The family unit of the participant that may be comprised, if such family relationship exists, of the spouse and dependent children covered under the Program, and the dependent parent enrolled in the Parent Medical Coverage.

2.1.9. Disability: A physical or mental handicap, as certified in accordance with Bank procedures and accepted by the Bank's medical reviewer.

2.1.10. Waiver: Non-participation in the Medical Insurance Program which is approved by the Bank.

2.1.11. Alternate Coverage: Insurance coverage held by the staff member and deemed by the Bank as comparable to the Program's coverage for purposes of a Waiver for the staff member. Insurance coverage held by dependents and deemed by the Bank as acceptable for purposes of a Waiver for dependents.

2.1.12. Vesting: The grant of entitlement to the Retiree Medical Insurance Program on behalf of a participant as established in Annex 1 of this Staff Rule.

2.1.13. Years of Participation: The number of full years of service (i.e., complete 12-month periods) that the participant was covered under the Medical Insurance Program.

2.1.14. Continuous Participation: For vesting purposes, refers to participation in the Medical Insurance Program without interruption, notwithstanding a change in the employment contract with the Bank from national to international staff member or vice versa.

2.1.15. Non-continuous Participation: For vesting purposes, for staff hired on or after January 1, 2015 and for services rendered on or after January 1, 2015 as national or international staff, refers to participation in the Medical Insurance Program which may be discontinued due to a Waiver, or a break in employment with the Bank.

2.1.16. Premium: Cost of participation in the Program. The Premium varies depending upon the eligibility class of the participant as further defined in this Staff Rule. Premium amounts will be higher for non-vested retirees and for retirees who become vested under a progressive schedule. The payment for Parent Medical Coverage is a separate Premium, in addition to other premium amounts payable by a participant. The Bank may modify all premiums from time to time.

2.1.17. Basic Premium for Active International Staff: Except as expressly provided hereby, the cost, as published by the Bank, of participation in the Program while on active service. This rate will also be applicable for staff on Long Term Disability as per paragraph 8.1 of this Staff Rule.

2.1.18. Basic Premium for International Staff on Prolonged Leave without Pay: The cost as published by the Bank for staff members who are on extended leave of absence as regulated by Staff Rule PE-355 "Leave without Pay". This rate will also be applicable for continued participation in the Program after termination of service, as per paragraphs 6.1.2 or 6.1.3 of this Staff Rule.

2.1.19. Basic Premium for Non-Vested International Retirees: The cost as published by the Bank for retirees who were hired as staff before January 1, 2015 and who did not fulfill the corresponding Vesting criteria before pension commencement.

2.1.20. Basic Premium for Vested International Retirees: The cost as published by the Bank for retirees who have fulfilled the corresponding vesting criteria.

2.1.21. Basic Premium for International Retirees under a Progressive Schedule: The cost as published by the Bank for retirees who were hired as staff on or after January 1, 2015 and who fulfilled some or all of the vesting criteria before pension commencement. The Basic Premium for International Retirees under a

Progressive Schedule is equal to the Basic Premium for Vested International Retirees multiplied by a progressive vesting factor, which is a component linked to the Years of Participation for Vesting.

2.1.22. Parent Medical Coverage Cost for International Participants: Amount as published by the Bank to be paid by the participant on behalf of a covered dependent parent.

2.1.23. Qualifying Life Event: An event which constitutes a reason determined by the Bank to allow a waived staff member, or waived staff member and dependent child and/or spouse to enroll in the Program, after a decision to opt out by the staff member was made. Qualifying Life Events are limited to: death of a spouse or domestic partner providing Alternate Coverage; termination of employment of spouse providing Alternate Coverage; legal separation or divorce from spouse providing Alternate Coverage for the dependent children; or a significant change to the Alternate Coverage, excluding voluntary loss of that coverage, that causes loss of comparable coverage for the Waived staff member. Unless there is a Qualifying Life Event, a waiver decision is final. Proof of the occurrence of the Qualifying Life Event is required.

3. PARTICIPATION IN THE MEDICAL INSURANCE PROGRAM

3.1. MANDATORY PARTICIPATION

3.1.1. All international Bank staff with employment contracts defined in Staff Rule PE-311 "Types of Appointments", and their respective spouses and dependent children, must participate in the Medical Insurance Program.

3.1.2. Staff may request, in writing, a Waiver as a result of having Alternate Coverage as defined in paragraphs 2.1.10 and 2.1.11.

3.1.3. The Bank offers five options: (a) individual coverage for the staff member only, when either the staff member has no dependents, or the spouse and dependent children are waived; (b) family coverage for the staff member, spouse and dependent children; (c) no coverage, neither the staff member nor dependents are covered because they are all waived; (d) family coverage for staff member and all dependent children, with only the spouse being waived; and (e) single parent coverage for the staff member and all dependent children, when the staff member has no spouse. In options (d) and (e) all dependent children must be covered by the staff member.

3.1.4. Staff members and dependents waived from the Program, will be allowed to enroll thereafter only if a Qualifying Life Event as described in paragraph 2.1.23 occurs. This provision does not apply to a dependent parent.

3.2. VOLUNTARY PARTICIPATION

3.2.1. Participation in the Medical Insurance Program will be optional for:

3.2.1.1. Executive Directors, their Alternates, Counselors and Co-Terminous Office Assistants, and their dependents[1] who will be automatically enrolled into the Medical Insurance Program effective as of the hire date, and who must request in writing their exclusion from the Program to terminate participation.

3.2.1.2. Children of the staff member or spouse of the staff member who do not qualify as dependent children for purposes of Bank policy, regardless of whether (a) they reside with the staff member, or (b) are married. Such coverage ceases on the child's 26th birthday.

1 For Staff Office Assistants assigned to the Office of Executive Directors, participation in the Medical Insurance Program of the Bank is mandatory as defined in 3.1.1 of this Staff Rule.

3.2.2. Individuals mentioned in paragraph 3.2.1.1 and 3.2.1.2 who have decided not to participate in the Program will be allowed to enroll thereafter only if a Qualifying Life Event as described in paragraph 2.1.23 occurs.

4. ENROLLMENT IN THE MEDICAL INSURANCE PROGRAM

4.1. Staff subject to mandatory participation will begin such participation:

4.1.1. On the effective date of hire, or

4.1.2. On the effective date of termination of Alternate Coverage due to a Qualifying Life Event as per paragraph 2.1.23. All staff must notify the Bank immediately of the termination of such Alternate Coverage. For any period of retroactive coverage, the corresponding premiums are payable by the staff member to the Bank.

4.2. Once the staff member is already a participant of the Medical Insurance Program:

4.2.1. Coverage for a new spouse and/or children will begin on the effective date that the dependent status is recognized by the Bank. Coverage for a newborn is retroactive to the moment of birth, as long as such birth is on or subsequent to the effective date of hire of the staff.

4.2.2. Medical insurance coverage for dependent children may continue beyond age 26 only in cases of disability. However, in those cases, if the staff member requests interruption of coverage or the child ceases to be disabled, later in the future, then a future renewal of coverage for that child will not be permitted, except as provided in paragraph 3.1.4.

5. VESTING CRITERIA TO PARTICIPATE IN THE RETIREE MEDICAL INSURANCE PROGRAM

5.1. Staff members who terminate employment with the Bank and are eligible to receive a pension under the Bank's Retirement Plans, may participate in the Medical Insurance Program as retirees, along with their dependents, provided the conditions and minimum number of years of participation for vesting in the Program are met as specified in Annex 1 of this Staff Rule.

6. ENDING ENROLLMENT

6.1. ON TERMINATION OF EMPLOYMENT WITH THE BANK

6.1.1. With the exception of staff who retire with an immediate pension and continue participation in the Retiree Medical Insurance Program, staff members who terminate employment with the Bank and their dependents will cease to participate in the Medical Insurance Program thirty (30) calendar days after the effective date of such termination of employment.

6.1.2. Staff hired prior to September 1, 1995 who deferred their pension may continue participating in the Medical Insurance Program beyond the thirty (30) days mentioned in paragraph 6.1.1, and may continue the participation of their dependents, until the effective date of the staff member's retirement, provided the staff members pay in advance, the Basic Premium for International Staff on Prolonged Leave without Pay.

6.1.3. Staff hired on or after September 1, 1995 may continue participating in the Medical Insurance Program beyond the thirty (30) days mentioned in paragraph 6.1.1, and may continue the participation of their dependents, for an additional five (5) calendar months, provided they pay in advance, the Basic Premium for International Staff on Prolonged Leave without Pay.

6.1.4. Vesting criteria in relation to continued participation in the Medical Insurance Program after termination of service, as per paragraphs 6.1.2 and 6.1.3, is established in Annex 1 of this Staff Rule.

6.2. ON TERMINATION OF DEPENDENT STATUS

6.2.1. The participation in the Medical Insurance Program of an insured ex-spouse, and insured former dependent child, will cease thirty (30) calendar days after the effective date of a staff member's legal separation or divorce, the effective date of the "Declaration of Termination of Domestic Partnership", or the date on which the condition of dependent child ceases, as it may be applicable.

6.3. AFTER ENDING ENROLLMENT

6.3.1. The additional thirty-day (30) coverage period beyond termination of employment, or termination of dependent status, will be at no cost to the staff member.

7. STAFF ON PROLONGED LEAVE WITHOUT PAY

7.1. Staff absent on prolonged leave without pay for a period of more than thirty (30) calendar days will cease to participate in the Medical Insurance Program, along with their dependents, thirty (30) calendar days after the effective date on which the leave of absence was initiated.

7.2. This additional thirty (30) day coverage period is at no cost to the staff member, consistent with paragraph 6.3.1 of this Staff Rule.

7.3. With the Bank's approval, staff members will have the option of continuing their participation in the Medical Insurance Program during the period of prolonged leave without pay, as long as they pay in advance the Basic Premium for International Staff on Prolonged Leave without Pay.

7.4. Vesting criteria in relation to continued participation in the Medical Insurance Program while on prolonged leave without pay is established in Annex 1 of this Staff Rule.

8. STAFF ON LONG TERM DISABILITY

8.1. Staff who become incapacitated and are placed on long term disability, under the Life and Disability Insurance Program of the Bank, may continue participation in the Medical Insurance Program along with their dependents, upon initiation of the disability.

8.2. The amount that staff will pay for participation in the Medical Insurance Program during the period of long term disability will be the Basic Premium for Active International Staff.

8.3. Vesting criteria in relation to continued participation in the Medical Insurance Program while on long term disability is established in Annex 1 of this Staff Rule.

9. PARENT MEDICAL COVERAGE

9.1. Participation under the Parent Medical Coverage as defined in paragraph 2.1.2 is optional and must be requested by the staff member in writing after the Bank has officially recognized the dependent status. The dependent parent will be required to have a complete medical evaluation for determination of any pre-existing condition.

9.2. Staff members who have chosen not to enroll a dependent parent within thirty (30) days from the date the Bank has officially recognized the dependent status or have chosen to opt out of the Program shall not be allowed to enroll in the Program thereafter.

9.3. Coverage under the Parent Medical Coverage could begin as early as the effective date on which the Bank has recognized the parent as a dependent of the staff member, but only after the staff member has submitted to the Bank a medical evaluation, and it has been assessed and accepted accordingly to the satisfaction of the Bank.

9.4. The staff member is responsible for payments of the Parent Medical Coverage Cost for International Participants, which will be in effect upon coverage commencement.

9.5. The terms of coverage under the Parent Medical Coverage for the dependent parent shall be subject to the exclusion that benefits shall not be payable for treatment of a condition or conditions pre-existing, present or identified, on the date of initiation of coverage. Such exclusion shall remain in effect for the first five (5) years of continuous coverage.

9.6. Coverage for a parent, who is no longer recognized as dependent by the Bank, will cease thirty (30) calendar days after the date on which dependent status was terminated, at no cost to the staff member, consistent with paragraph 6.3.1.

10. SPECIAL PROVISIONS

10.1. In such cases when a staff member passes away in active service, who at the time of death was covered under the Bank's Medical Insurance Program, and the surviving spouse starts receiving a survivor's pension from the Bank's Retirement Plans:

10.1.1. The surviving spouse will be eligible to continue participating in the Retiree Medical Insurance Program.

10.1.2. The corresponding Medical Insurance premium will be computed as if the staff member had participated in the Program for a period of five (5) years, or the number of years of service projected to what would have been the staff member's normal retirement, whichever period is greater.

11. MISREPRESENTATION AND FRAUDULENT CLAIMS

11.1. Participants must notify the Bank of any changes affecting the eligibility of their dependents or themselves for participation in the Medical Insurance Program.

11.2. All participants are also expected to submit claims consistently with the rules and procedures applicable to the Program and to be truthful in their dealings with the Bank and with the Program Administrator.

11.3. All participants must also cooperate with any audit, investigation or other inquiry regarding their participation and/or the participation of their dependents in the Program.

11.4. Any corrupt practice, misrepresentation, falsification of claims, other fraud, failure to cooperate with an investigation or other obstruction of an investigation, or any other wrongdoing related to participation in the Program shall be considered serious misconduct. The consequences of such misconduct may include, but shall not be limited to disciplinary sanctions, which for staff may include the termination of employment; loss of eligibility to continue participation in the Program; the offset of other payments, including in the form of payments from the Program or other payments due from the Bank, to compensate the Program for wrongfully-paid amounts; and other process for the restitution to the Program or the Bank, as applicable, for lost amounts.

11.5. The Bank may also refer any suspected violation of national law to the appropriate authorities.

12. RECOVERY OF OVERPAYMENT

12.1. Any participant who knows that the Bank has made an overpayment should immediately report the overpayment to the Bank.

12.2. In the event of overpayment to a participant on a claim, the Bank shall have the right to the immediate repayment to the Bank of overpaid amounts upon written notice by the Bank to the participant.

12.3. When the participant is a staff member, spouse, dependent child or dependent parent, failure to promptly repay such amounts by such staff member shall be considered misconduct and may be subject to disciplinary sanctions. Further, the Bank shall have the authority to recover overpaid amounts through deduction from any other payments due from the Bank to the staff member in one or more installments, of not less than ten percent (10%) of the total amount (after any other deductions) of each such payment payable by the Bank.

12.4. The Bank may also undertake any other process for the restitution of funds to the Program or the Bank, as applicable, for lost amounts.

PE-375 ANNEX 1 VESTING CRITERIA FOR THE RETIREE MEDICAL INSURANCE PROGRAM

Effective: August 2017

INTRODUCTION

The purpose of this Annex is to establish and regulate the criteria for international staff to be vested for participation in the Medical Insurance Program as retirees. The applicable vesting criteria depends, in part, on the staff member´s corresponding date of hire. For individuals with periods of discontinuous Bank employment, the hiring date that applies is the hiring date corresponding to the latest period of continuous Bank employment ending with retirement.

1. STAFF HIRED PRIOR TO SEPTEMBER 1, 1995

1.1. IMMEDIATE PENSION

1.1.1. Staff members hired prior to September 1, 1995 who leave employment with the Bank and retire with an immediate pension, either at normal retirement age or when entitled to an early retirement, will be eligible for participation in the Retiree Medical Insurance Program paying the Basic Premium for Vested International Retirees, provided they have had at least three (3) years of continuous participation in the Medical Insurance Program as an active staff member prior to their retirement date.

1.1.2. Staff members hired prior to September 1, 1995 who were not able to fulfill the corresponding vesting criteria before retirement, will be allowed to reach such vesting criteria upon pension commencement by accruing the necessary number of years to reach the three (3) years of continuous participation.

1.1.2.1. During this time staff members will have to pay the Basic Premium for Non-Vested International Retirees until they have reached the corresponding vesting criteria.

1.2. DEFERRED PENSION

1.2.1. Staff members hired prior to September 1, 1995 who leave employment with the Bank with a deferred pension will be eligible to participate in the Retiree Medical Insurance Program paying the Basic Premium for Vested International Retirees upon pension commencement provided, at the time of such retirement, they have had at least three (3) years of continuous participation in the Medical Insurance Program.

1.2.2. Staff members hired prior to September 1, 1995 who were not able to fulfill the corresponding vesting criteria before retirement and who have opted to keep participating in the Medical Insurance Program after termination date and before pension commencement (paying the Basic Premium for International Staff on Prolonged Leave without Pay), will count this time period toward the accumulation of the corresponding three (3) years of continuous participation in the Medical Insurance Program.

1.2.3. Staff members hired prior to September 1, 1995 who were not able to fulfill the corresponding vesting criteria before retirement, will be allowed to reach such vesting criteria after pension commencement.

1.2.3.1. Staff members will be required to complete three (3) years of continuous participation paying the Basic Premium for Non-Vested International Retirees.

1.2.3.2. Once staff members reach the vesting criteria, they will pay the Basic Premium for Vested International Retirees.

1.3. PROLONGED LEAVE WITHOUT PAY

1.3.1. Participation in the Medical Insurance Program while on prolonged leave without pay (paying in advance the Basic Premium for International Staff on Prolonged Leave without Pay) will count for vesting criteria towards Retiree Medical Insurance Program.

1.4. MEDICAL INSURANCE WAIVER

1.4.1. Staff members, hired prior to September 1, 1995, who have waived their participation in the Medical Insurance Program at any time during active service with the Bank will have the opportunity to fulfill the corresponding vesting criteria upon termination of service, or after pension commencement.

1.5. PREMIUM COST

1.5.1. Staff members hired prior to September 1, 1995 will pay the Basic Premium for Vested International Retirees, the Basic Premium for Non-Vested International Retirees, or the Basic Premium for International Staff on Prolonged Leave without Pay as applicable and as described in this Section.

2. STAFF HIRED ON OR AFTER SEPTEMBER 1, 1995 AND PRIOR TO JANUARY 1, 2015

2.1. IMMEDIATE PENSION

2.1.1. Staff members hired on or after September 1, 1995 and prior to January 1, 2015 who leave employment with the Bank and retire with an immediate pension, either at normal retirement age or when entitled to an early retirement, will be eligible for participation in the Retiree Medical Insurance Program paying the Basic Premium for Vested International Retirees, provided they have had at least five (5) years of continuous participation in the Medical Insurance Program as an active staff member prior to their retirement date.

2.1.2. Staff members hired on or after September 1, 1995 and prior to January 1, 2015 who were not able to fulfill the corresponding vesting criteria before retirement, will be allowed to reach such vesting criteria upon pension commencement by accruing the necessary number of years to reach the five (5) years of continuous participation.

2.1.2.1. During this time staff members will have to pay the Basic Premium for Non-Vested International Retirees until they have reached the corresponding vesting criteria.

2.2. DEFERRED PENSION

2.2.1. Staff members hired on or after September 1, 1995 and prior to January 1, 2015 who leave employment with the Bank with a deferred

pension will be eligible to participate in the Retiree Medical Insurance Program paying the Basic Premium for Vested International Retirees upon pension commencement provided, at the time of such retirement, they have had at least five (5) years of continuous participation in the Medical Insurance Program.

2.2.2. Staff members hired on or after September 1, 1995 and prior to January 1, 2015 who were not able to fulfill the corresponding vesting criteria before retirement and who have opted to keep participating in the Medical Insurance Program after termination date for up to five (5) additional months (paying in advance the Basic Premium for International Staff on Prolonged Leave without Pay), will count this time period toward the accumulation of five (5) years of continuous participation in the Medical Insurance Program.

2.2.2.1. The additional thirty (30) days granted upon termination of service, as indicated in Staff Rule PE-375 paragraph 6.1.1 will count toward the accumulation of five (5) years of continuous participation in the Program.

2.2.3. Staff members hired on or after September 1, 1995 and prior to January 1, 2015 who were not able to fulfill the corresponding vesting criteria before retirement, will be allowed to reach such vesting criteria upon pension commencement.

2.2.3.1. Staff members will be required to complete five (5) years of continuous participation paying the Basic Premium for Non-Vested International Retirees.

2.2.3.2. Once staff members reach the vesting criteria, they will pay the Basic Premium for Vested International Retirees.

2.3. PROLONGED LEAVE WITHOUT PAY

2.3.1. Participation in the Medical Insurance Program while on prolonged leave without pay (paying in advance the Basic Premium for International Staff on Prolonged Leave without Pay) will count for vesting criteria towards Retiree Medical Insurance Program.

2.4. MEDICAL INSURANCE WAIVER

2.4.1. Staff members, hired on or after September 1, 1995 and prior to January 1, 2015, who have waived their participation in the Medical Insurance Program at any time during active service with the Bank will have the opportunity to fulfill the corresponding vesting criteria upon termination of service (as described in 2.2.2) or after pension commencement.

2.5. PREMIUM COST

2.5.1. Staff members hired on or after September 1, 1995 and prior to January 1, 2015 will pay the Basic Premium for Vested International Retirees, the Basic Premium for Non-Vested International Retirees, or the Basic Premium for International Staff on Prolonged Leave without Pay as applicable and as described in this Section.

3. STAFF HIRED ON OR AFTER JANUARY 1, 2015

3.1. IMMEDIATE PENSION

3.1.1. Staff members hired on or after January 1, 2015 who leave employment with the Bank and retire with an immediate pension, either at normal retirement age or when entitled to an early retirement, will be eligible for participation in the Retiree Medical Insurance Program paying the Basic Premium for Vested International Retirees provided they have had at least twenty (20) years of participation, continuous or non-continuous, in the Medical Insurance Program as an active staff member prior to their retirement date.

3.1.2. Staff members hired on or after January 1,

2015 who have not been able to accumulate twenty (20) years of participation, must have accumulated a minimum number of years to be eligible to participate in the Retiree Medical Insurance Program. The required minimum number of years of participation, continuous or non-continuous, in the Medical Insurance Program as an active staff member prior to their retirement date are as follows:

3.1.2.1. Five (5) years in the case of normal retirement.

3.1.2.2. Ten (10) years in the case of early retirement.

3.1.3. NOT ELIGIBLE TO PARTICIPATE. Staff members hired on or after January 1, 2015 who retire with an immediate pension and have not accumulated the corresponding minimum number of years of participation in the Medical Insurance Program, as an active staff member as established above, will not be eligible to participate in the Retiree Medical Insurance Program.

3.2. DEFERRED PENSION

3.2.1. Staff members hired on or after January 1, 2015 who leave employment with the Bank with a deferred pension, will be eligible to participate in the Retiree Medical Insurance Program paying the Basic Premium for Vested International Retirees provided they have had at least twenty (20) years of participation, continuous or non-continuous, in the Medical Insurance Program as an active staff member prior to termination of service.

3.2.2. Staff members who leave the Bank with a Deferred Pension will be eligible to participate in the Retiree Medical Insurance Program upon pension commencement provided they have accumulated a minimum number of years of participation, continuous or non-continuous, in the Medical Insurance Program as an active staff member prior to termination of service as follows:

3.2.2.1. Five (5) years in the case of a deferred pension to become effective at normal retirement age.

3.2.2.2. Ten (10) years in the case of a deferred pension to become effective at early retirement age.

3.2.3. NOT ELIGIBLE TO PARTICIPATE. Staff members hired on or after January 1, 2015 who leave employment with the Bank with a Deferred Pension, and who do not have accumulated the corresponding minimum number of years of participation in the Medical Insurance Program as an active staff as established above, will not be eligible to participate in the Retiree Medical Insurance Program.

3.3. FULFILLING VESTING CRITERIA

3.3.1. Staff members hired on or after January 1, 2015 must fulfill the corresponding vesting criteria during active service. In case that the vesting criteria are not reached during active service, staff members will not be allowed to reach such vesting criteria upon pension commencement.

3.4. PROLONGED LEAVE WITHOUT PAY

3.4.1. Participation in the Medical Insurance Program while on prolonged leave without pay (paying in advance the Basic Premium for International Staff on Prolonged Leave without Pay) will count for vesting criteria towards Retiree Medical Insurance Program.

3.5. MEDICAL INSURANCE WAIVER

3.5.1. Staff members, hired on or after January 1, 2015, who have completely waived their participation in the Medical Insurance Program for the entire duration as an active staff member with the Bank will not be eligible to participate in the Retiree Medical Insurance Program.

3.5.2. For staff who have waived their participation in the Medical Insurance Program, at any time

during active service, total periods of participation as an active staff member will count towards vesting for Retiree Medical as established in this Annex.

3.6. PREMIUM COST

3.6.1. Staff members hired on or after January 1, 2015, will pay the Basic Premium for Vested International Retirees, the Basic Premium for International Staff on Prolonged Leave without Pay, or the Basic Premium for International Retirees under the Progressive Schedule as applicable and as described in this Section.

3.7. PREMIUM AMOUNT CALCULATION

3.7.1. Staff members hired on or after January 1, 2015 who did not accumulate at least twenty (20) years of participation in the Medical Insurance Program, will pay the Basic Premium for International Retirees under the Progressive Schedule. Staff members follow a progressive schedule in determining the premium amount to be paid upon pension commencement in which the premium amount will be reduced according to the Years of Participation for Vesting in the Medical Insurance Program during active service.

3.7.2. Provided that the staff member has reached the minimum Participation Years as established in this Annex, the total number of Years of Participation for Vesting in the Medical Insurance Program of the staff member will be considered to determine the progressive vesting factor. Whole years of participation in active service will be considered. A partial year (less than 12 months) does not constitute a whole year of participation.

3.7.3. Upon pension commencement, the staff member will pay the Basic Premium for International Retirees under a Progressive Schedule taking into account the relevant progressive vesting factor.

3.7.4. Staff members will not be able to modify/reduce the progressive vesting factor's level upon pension commencement.

3.7.5. The necessary information to compute the Premium amount to be paid will be published by the Bank.

PE-375 ANNEX 2 MEDICAL INSURANCE PROGRAM FOR RETIREES

Effective: August 2017

INTRODUCTION

The purpose of this Annex is to present the general terms and conditions related to international retirees and their dependents participating in the Medical Insurance Program.

1. PARTICIPATION IN THE MEDICAL INSURANCE PROGRAM

1.1. All international Bank retirees, vested in the Medical Insurance Program[1], along with their respective dependents may participate in the Medical Insurance Program.

2. VOLUNTARY ENROLLMENT

2.1. All eligible Bank retirees must make the decision whether to participate or not in the Medical Insurance Program when applying for a pension under the Bank's Retirement Plans.

2.2. If the retiree decides not to participate in the Program when applying for a pension, this decision will be irrevocable and the retiree will not have an opportunity thereafter to be covered under the Program as a retiree.

1 International Bank retirees vested in the Medical Insurance Program include those who accumulated a minimum number of years of participation in the Program under the progressive schedule as per paragraphs 3.1.2 and 3.2.2 of PE-375 Annex 1.

2.2.1. Dependents of a retiree who has chosen not to participate in the Medical Insurance Program are not eligible to be covered under the Program.

2.3. If the retiree decides to participate in the Medical Insurance Program, participation of his/her dependents will be optional. The retiree must register a dependent as a participant in the Medical Insurance Program upon retirement, within 30 days of the dependent's eligibility for participation subsequent to retirement, or at such other time as deemed by the Bank.

2.3.1. Coverage for a new spouse and/or child will begin on the effective date that they are recognized as dependents of the retiree. Coverage for a newborn is retroactive to the moment of birth as long as such birth is on or subsequent to the effective date of pension commencement under the Bank's Retirement Plans.

2.3.2. Children of the retiree or spouse of the retiree may be covered even if (a) they do not reside with the retiree, or (b) are married. Such coverage ceases on the child's 26th birthday.

2.3.3. Medical Insurance Program coverage for dependent children may continue beyond age 26 only in cases of disability. However, in those cases, if the retiree requests interruption of coverage or the child ceases to be disabled, then a future renewal of coverage for that child will not be permitted.

2.4. When both spouses are Bank retirees, or a combination of Bank staff and retiree, and both participate in the Medical Insurance Program, only one monthly contribution for the family will be deducted which will be from the spouse with the higher premium. In cases where one or both spouses are retirees vested under a progressive schedule, the Years of Participation for Vesting for each of the spouses (whichever is the most favorable for these participants) will be taken into consideration to determine the Premium payment for the family.

3. PARENT MEDICAL COVERAGE

3.1. The dependent parent of the retiree with an immediate pension can continue to participate in the Parent Medical Coverage, provided that the parent was recognized as the retiree's dependent parent at the time of his/her termination of service with the Bank, and the dependent parent was enrolled in the Parent Medical Coverage for at least five (5) continuous years immediately prior to that time.

3.2. The retiree may opt to discontinue the participation of her/his dependent parent by providing notification to the Bank thirty (30) calendar days in advance, and this decision will be definite and irrevocable.

4. ENDING ENROLLMENT

4.1. The retiree may opt to discontinue his/her participation in the Medical Insurance Program by providing notification to the Bank thirty (30) calendar days in advance. This decision will be definite and irrevocable.

4.2. The participation in the Medical Insurance Program of an insured ex-spouse, and insured former dependent child, will cease thirty (30) calendar days after the effective date of a retiree's legal separation or divorce, the effective date of the "Declaration of Termination of Domestic Partnership", or the date on which the condition of dependent child ceases, as it may be applicable.

4.3. AFTER ENDING ENROLLMENT. The additional thirty (30) day coverage period beyond termination of coverage will be at no cost to the retiree.

5. SPECIAL PROVISIONS

5.1. The provisions stated in paragraph 5.2 apply to events that happen on or after January 1, 2015.

5.2. In such cases when the retiree passes away, the retiree's dependents will be eligible for continued participation based on the following criteria:

5.2.1. If the retiree passes away and the surviving spouse was the spouse of the retired participant on the last day of the retiree's active service, and the surviving spouse continues receiving a pension from the Bank's Retirement Plans, continued participation in the Medical Insurance Program requires payment of the Basic Premium for Vested International Retirees, or the Basic Premium for International Retirees under a Progressive Schedule (at the same progressive vesting factor level as the deceased retiree), whichever is applicable, without having to comply with the ten (10) year criteria stated in paragraph 5.2.2.

5.2.2. If the retiree passes away and the surviving spouse became the spouse of the retired participant after the last day of active service and he/she continues receiving a pension from the Bank's Retirement Plans and, if at the time of death, the surviving spouse was married, or maintained a domestic partnership declared/registered with the Bank, with the deceased retiree for ten (10) years or more, continued participation in the Medical Insurance Program requires payment of the Basic Premium for Vested International Retirees, or the Basic Premium for International Retirees under a Progressive Schedule (at the same progressive vesting factor level as the deceased retiree) whichever is applicable. However, if the surviving spouse was not married, or did not maintain a domestic partnership, to the deceased retiree for ten (10) years or more, and the surviving spouse continues receiving a pension from the Bank's Retirement Plans, continued participation in the Medical Insurance Program is possible by paying the Basic Premium for Non-Vested International Retirees.

5.2.3. If the surviving spouse, receiving a pension from the Bank's Retirement Plans, keeps participating in the Medical Insurance Program (along with his/her corresponding eligible dependents) and remarries or establishes a domestic partnership, the new spouse, and the children of the new spouse including newborns, will not be eligible to participate in the Medical Insurance Program.

5.3. In cases when the retiree passes away, and the dependent children become orphans, and are receiving a Children's Benefit from the Bank's Retirement Plans, the dependent children will be able to continue participating in the Medical Insurance Program paying the Basic Premium for Vested International Retirees or the Basic Premium for International Retirees under a Progressive Schedule (at the same progressive vesting factor level as the deceased retiree) or the Basic Premium for Non-Vested International Retirees as applicable, until they cease to receive the Children's Benefit.

5.4. For instances where the retirees' corresponding Premium cannot be deducted in part or in its entirety from the Retiree's pension, the retiree will be required to cover the Premium difference in advance. Whenever the retiree is not able to cover the monthly Premium (in part or in its entirety), the retiree and his/her dependents will cease to participate in the Medical Insurance Program.

6. MEDICAL INSURANCE PREMIUM PROTECTION

6.1. For retirees receiving a pension before January 1, 2015, the Bank may provide a Premium relief for those receiving a low-income pension, following procedures approved by the Bank.

7. MISREPRESENTATION AND FRAUDULENT CLAIMS

7.1. Participants must notify the Bank of any changes affecting the eligibility of their dependents or themselves for participation in the Medical Insurance Program.

7.2. All participants are also expected to submit claims consistently with the rules and procedures applicable to the Program and to be truthful in their dealings with the Bank and with the Program Administrator.

7.3. All participants must also cooperate with any audit, investigation or other inquiry regarding their participation and/or the participation of their dependents in the Program.

7.4. Any corrupt practice, misrepresentation, falsification of claims, other fraud, failure to cooperate with an investigation or other obstruction of an investigation, or any other wrongdoing related to participation in the Program shall have consequences such as loss of eligibility to continue participation in the Program; the offset of other payments, including in the form of payments from the Program or other payments due from the Bank, to compensate the Program for wrongfully-paid amounts; and other process for the restitution to the Program or the Bank, as applicable, for lost amounts.

7.5. The Bank may also refer any suspected violation of national law to the appropriate authorities.

8. RECOVERY OF OVERPAYMENT

8.1. Any participant who knows that the Bank has made an overpayment should immediately report the overpayment to the Bank.

8.2. In the event of overpayment to a participant on a claim, the Bank shall have the right to the immediate repayment to the Bank of overpaid amounts upon written notice by the Bank to the participant.

8.3. The Bank may also undertake any other process for the restitution of funds to the Program or the Bank, as applicable, for lost amounts.

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