MEDICAL BENEFITS PROGRAM HANDBOOK

Active and Retired Staff | INTERNATIONAL

NOVEMBER **2023**

IDB | IDB Invest | IDB Lab

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ABOUT THIS HANDBOOK

This handbook provides information about the Inter-American Development Bank Group (IDB Group) Medical Benefits Program[1].

The program includes coverage for:

- Medical
- Prescription Drugs
- Vision
- Dental

This 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 assistance. Actual benefits will be granted in accordance with the provisions of the different plans that comprise the Medical Benefits Program.

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

A glossary of terms can be found at the end of the handbook for reference.

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

[1]This handbook applies to the Inter-American Development Bank, IDB Invest, and IDB Lab, collectively the "IDB Group."

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. Members based in the U.S. and Puerto Rico have access to in-network benefits through Cigna Healthcare's broadest preferred provider network and may also choose to use out-of-network providers with no referrals required. Members based outside the U.S. or Puerto Rico have access to Cigna Global's broad network of providers and may also choose out-of-network providers; when receiving services in the U.S., overseas members have access to the Cigna Healthcare network, however claims are handled through Cigna Global. 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 prescribed lenses, and prescribed contact lenses.
Dental	Covers a portion of the cost of preventive care, diagnostic care, and basic and major restorative care. Includes also benefits for orthodontics.

1.2 NEW TO THE PROGRAM

Generally, 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 program administrators are external companies contracted by the IDB Group to process claims, furnish network providers, and provide other services for the different plans. Currently, if you live in the U.S. or Puerto Rico, Cigna Healthcare administers your medical, dental and vision services and Express Scripts administers prescription drug services. If you live outside the U.S. or Puerto Rico, Cigna Global administers your medical, dental, vision and prescription drug services.

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 Human Resources Services Division of the Department of Human Resources (HRD) supports the IDB Group in the provision of coverage for medical, dental, prescription drugs, and vision benefits; life and accidental death & dismemberment (AD&D) insurance; and Long-Term Disability (LTD) coverage to plan members.

The EW&HB team manages the relationship with the program administrators that provide services associated with health benefits, and with the carrier that provides the insurance policies and services for life, accident, death and dismemberment (AD&D), and long-term disability (LTD) benefits.

You may contact the EW&HB team to request information on filing an appeal for a denied health claim or procedure; request the nomination of providers to be added to one of the plan administrators' networks; or for any other questions regarding your health benefits.

Website & E-mail
https://idbg.sharepoint.com/sites/HR
HRD/INS@iadb.org
www.iadb.org/retirees

Phone
1-202-623-3090

Mail
IDB Employee Wellbeing & Health Benefits Team
1300 New York Avenue NW
Mail Stop E-0403, Washington, DC 20577

For further information about eligibility and claim reimbursements, 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 IDB Group staff to maintain a healthy lifestyle. Services offered include:

Employee Assistance Program (EAP). 24/7 free, confidential advice, support and referrals for IDB Group staff, retirees and all 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 include on-site nurse, emergency care, medical exams, and lab services. Services offered in both headquarters and country offices include case management, referrals, counseling, health education, travel medicine and occupational medicine.

Wellness Programs. Raise awareness and provide opportunities for action on specific health related matters through the annual health fair, wellness challenges, ergonomic evaluations, as well as well-being related seminars and services.

Facilities. Lactation room (Headquarters and Country Offices as applicable), Quiet Room (Headquarters), and Fitness Center (Headquarters).

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

If you are injured or become ill due to a work-related incident, you must inform the IDB Group immediately to receive the needed support.

Location & Time	Who to Notify	Phone
Headquarters during business hours	Health Services Center Supervisor	202-623-3135
Headquarters outside of business hours	Security guard on duty	202-623-3300
Country Office*	Representative	
Traveling on official mission*	Mission Chief and/or Representative	

*During an official mission or if assigned to a Country Office, please notify the Representative or Mission Chief. They 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 provide network access.

The program administrator(s) of health benefits will depend on the place where the member officially resides.

If you live in the U.S. or Puerto Rico, Cigna Healthcare administers the medical, dental, and vision services while Express Scripts administers prescription drug services. If you receive medical services or fill a prescription outside the U.S. or Puerto Rico, you will file a claim with Cigna Healthcare for reimbursement.

If you live outside the U.S. or Puerto Rico, Cigna Global administers the medical, dental, vision, and prescription drug services. If you receive medical services or fill a prescription in the U.S., or in any other country where you don't officially reside, you will use your Cigna Global ID card.

Please note:

- You can contact your plan administrator to learn more about 1) How your benefits work; 2) What is covered; 3) Benefits and member eligibility; 4) Finding doctors or other health providers; and 5) Obtaining updates on the processing of your claims.

- You will need your ID number and account information when contacting your plan administrator. Contact information is available on the front or back of your Cigna Healthcare or Cigna Global ID card.

The plan administrators' secure websites allow you to submit and view status of claims, access provider 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 IDB Group is in the U.S. or Puerto Rico, the plan administrator for medical, dental, and vision benefits wherever you receive care worldwide is Cigna Healthcare.	my.cigna.com iadb@cigna.com	+1-800-IDB-3637 (1-800-432-3637) 24/7/365 Customer service in English and Spanish	Medical Claims: Cigna Healthcare P.O. Box 182223, Chattanooga, TN 37422-2223 Dental Claims: Cigna Dental P.O. Box 188037, Chattanooga, TN 37422-8037 Vision Claims: Cigna Vision P.O. Box 385018, Birmingham, AL 35238-5018
If your official residence registered with the IDB Group is in the U.S. or Puerto Rico, the plan administrator for pharmacy benefits is Express Scripts, Inc. If you travel abroad, you will pay for any prescriptions purchased and file a claim for reimbursement with Cigna Healthcare	www.express-scripts.com	1-855-521-0824 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 IDB Group is outside of the U.S. or Puerto Rico, the plan administrator for medical, dental, vision, and prescription drug benefits wherever you receive care worldwide is Cigna Global.	cignahealthbenefits.com iadb.global@cigna.com All options to contact Cigna Global will be listed on the Cigna Health Benefits website and mobile app. After logging in, select the "Contact" tab to see them. This tab also includes a "Call-me-back" feature, which allows Cigna Global to call you directly so that you do not incur long-distance charges.	Cigna Global Global phone: +32 3 293 18 59 **U.S. toll-free phone:** **+1 800 297 9983** Fax: +32 3 663 28 55 24/7/365 Customer service in English, Spanish, French and Portuguese	Cigna Global P.O. Box 69, 2140 Antwerpen, Belgium P.O. Box 451989 Sunrise, Florida 33345

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 the attached Staff Rule PE-375 and its Annexes 1 & 2. (See Appendix on Staff Rule PE-375 at this end of this handbook.)

1.8 THE IDB GROUP MOBILE WEB APP

The IDB Group has created a reference tool for members of the Medical Benefits Program: the Medical Benefits Mobile Web App, which provides easy access to information about the Medical Benefits Program for you and your dependents covered under the Program.

The Medical Benefits Web App features information about the components of the Program, including:

- **Current medical, dental, vision and prescription drug benefitsContact informationOther benefits**

No credentials or passwords are needed to access the Medical Benefits Mobile Web App. It contains no personalized data, and it can be accessed wherever there is an internet connection.

For instructions to download the app, click here.

Please share this Mobile Web App with any dependents you cover under the Program.

SECTION 2

MEDICAL PLAN

SECTION 2. MEDICAL PLAN

The Medical Plan provides comprehensive medical benefits that are determined to be medically necessary 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 for illness or injury
- Preventive care
- Inpatient hospital services
- Outpatient services at hospitals, doctors' offices, and other facilities
- Emergency care
- Urgent care

The plan is called an Indemnity Health Plan and it reimburses you after you have incurred expenses and have filed a claim with your plan administrator. Note that if you see in-network providers, they will file a claim on your behalf, and you will only pay the applicable coinsurance or co-pay amount.

If you need medical services in the U.S. or Puerto Rico, you have access to Cigna Healthcare's network and could benefit from the discounted rates offered by its broadest network of preferred providers.

If you choose an out-of-network provider in the U.S. or Puerto Rico, you will pay more for your healthcare, including meeting the annual out-of-network deductible and a higher coinsurance percentage. Out-of-network providers are not obligated to check with the administrator in advance to see if your service or procedure is medically necessary or otherwise covered under the IDB Group Medical Benefits Program, so you are responsible for making sure you have coverage and understand what it will cost you before proceeding. Also, with out-of-network providers, you will usually be required to pay out of pocket for your service and then file your claim for reimbursement with the administrator. This puts you at risk of paying in full for a service that is not covered by our Program; and/or receiving a "balance bill" that you must pay for a covered service, since our Program will only reimburse you at the established Maximum Reimbursable Charge allowed for out-of-network services (MRC).*

2.1.1 CARE OUT OF THE UNITED STATES OR PUERTO RICO

If you receive medical attention outside the U.S or Puerto Rico, your claims will be paid at the in-network benefit level regardless of where you receive service. However, if you are planning a costly procedure, you must reach out to the administrator at the phone number on the front or back of your card in advance to request a Guarantee of Payment (GOP) to ensure that your procedure is covered, and the provider will be paid.

2.1.2 FINDING IN-NETWORK

Members residing in the U.S. or Puerto Rico should submit reimbursement requests for out-of-network services and any claims for services received outside the U.S. or Puerto Rico with Cigna Healthcare. Members residing outside the U.S. or Puerto Rico should file all reimbursement requests with Cigna Global.

PROVIDERS IN AND OUT OF THE US OR PUERTO RICO

For members residing in the U.S. or Puerto Rico, call the number on the back of your Cigna Healthcare ID card or use the provider search feature on the myCigna website or mobile app to find current information on network hospitals, doctors, and other health care providers in your area.

If you are based in the U.S. or Puerto Rico, to find an in-network pharmacy, call the number on your Express Scripts ID card or use the pharmacy search feature on the Express Scripts website (expressscripts.com)

* See Section 9, "Glossary of Benefit Terms" for a definition of MRC.

or Express Scripts mobile app.

For members residing outside the U.S. or Puerto Rico, to find an in-network provider use the provider search feature on the Cigna Health Benefits website or mobile app, or you can call the number on the front of your Cigna Global ID card. If you are outside your country of residency and require medical care, use the phone number on the front of your card to find providers in the U.S., Puerto Rico, or other countries.

Also, you can refer to contact information in Section 1.6.

2.1.3 "FLASH THE CARD" SERVICES

For members residing outside the U.S. or Puerto Rico, use the provider search tool on the Cigna Health Benefits website or mobile app to find flash-the-card providers. If "outpatient direct payment" (#2) is check-marked next to the provider's name, then you can show your ID card and Cigna Global will make a direct payment for the cost of your care up to $400 (the exact amount depends on Cigna Global's agreement with the provider). The provider will charge you for any coinsurance, if applicable. For services exceeding $400, you must request a Guarantee of Payment (GOP) from Cigna Global. Refer to Section 2.5.

2.1.4 IMPORTANT MEDICAL TERMS

To understand how the plan works, you should be familiar with a number of medical terms you will see frequently in connection with your benefits. You will find the complete list of medical terms in Section 9, "Glossary of Benefit Terms."

2.1.5 APPEALS

The Medical Plan provides for two levels of appeal if you disagree with the administrator's decision to deny a claim or the provision of a service. The first level of appeal is handled internally by the plan administrator, utilizing specialized personnel outside of the department that made the original denial decision. The second level of appeal, which is available if the first level of appeal has been exhausted, is provided by an independent outside party called an Independent Review Organization (IRO). Information on how to file an appeal is included in your Explanation of Benefits (EOB) from Cigna Healthcare or your Settlement Note (SN) from Cigna Global.

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:
A deductible is the specific dollar amount that a member must first pay before the Plan begins to pay a portion of your medical costs. If you only cover yourself under the Plan, once you meet the $500 individual deductible for out-of-network services, your claims will be paid at the coverage percentage established in this Manual and you will be responsible for any applicable coinsurance amount and the difference between the billed charge and the Maximum Reimbursable Charge (MRC) covered by the Program, if applicable. If you cover two or more people under the plan, as soon as a person meets the $500 deductible, that person's claims will be paid according to the coverage percentage established in this Manual. Then, as soon as other family members together reach a total of $1,000 in deductibles, claims of all family members will be paid at the coverage percentage established in this Manual, plus any difference between the billed charge and the MRC covered by the Program, if applicable.

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 the Maximum Reimbursable Charge ("MRC")	Not applicable	No

Calculation of out-of-pocket maximum:
An out-of-pocket maximum is the amount that you must meet for the Plan to begin paying your claims at 100% for eligible services. The out-of-pocket expenses that can be applied toward this maximum amount include deductible and coinsurance amounts. Your monthly insurance premiums do not apply to the out-of-pocket expense maximum.

Once you meet your out-of-pocket expense maximum, the Plan will then cover 100% of the contracted or Maximum Reimbursable Charge of a provider, depending on whether your provider is in or out of network, respectively. Please note that if an out-of-network provider's fee is greater than the Maximum Reimbursable Charge allowed, you could be responsible for a "balance bill," reflecting the difference between what the plan will pay and what the out of network provider billed. The Plan will not pay for that difference.

If you cover more than one person under the Plan, as soon as one person reaches the individual out-of-pocket maximum, his/her claims for the rest of the year will be paid as noted above. When the rest of your family members collectively meet the family out-of-pocket maximum, claims for your family will be paid as noted above.

	IN NETWORK The Plan Will Pay	OUT-OF-NETWORK The Plan Will Pay
Doctor's Office Visits		
• For Illness	90%	80% of the Maximum Reimbursable Charge (MRC)*, after deductible
Routine Preventive Care	100%	100% of MRC, after deductible

- For all ages-Includes coverage for standard annual physicals and services such as urinalysis, EKG, standard blood panels, and other standard laboratory tests as part of the preventive care benefit as defined by the administrator.
- For all ages-Immunizations (including cost of biologicals that are immunizations or medications for the purpose of travel).
- For adults-Includes routine annual mammogram, PAP smear, and PSA tests.
- Routine preventive care does not include "executive type" annual physical exams, "Life Line" screenings, or genetic testing packages.

* See Section 9, "Glossary of Benefit Terms"

	IN NETWORK The Plan Will Pay	OUT-OF-NETWORK The Plan Will Pay
Mental Health and Substance Abuse		
• Inpatient (Medical necessity review after 45 days.)	100%	80% of MRC, after deductible
• Outpatient-Physician's Office	90%	80% of MRC, after deductible
• Outpatient-All other Services	100%	80% of MRC, after deductible
Surgery	100%	80% of MRC, after deductible
Second Opinion for Surgery (includes Lab & X-ray)	100%	100% of MRC, after deductible
Pre-admission Testing (up to 7 days prior to surgery)	100%	80% of MRC, after deductible
Inpatient Hospital Facility Services		
• Semi-private (SP) room	100% (of negotiated rate)	80% of MRC, after deductible
• Private room	100% (of SP negotiated rate)	80% of MRC, after deductible (up to SP rate limit)
• Intensive Care Unit (ICU)	100% (of negotiated rate)	80% of MRC, after deductible (up to ICU daily rate limit)
• Doctor's Visits/Consultations	90%	80% of MRC, after deductible
• Professional Services	100%	80% of MRC, after deductible
Outpatient Surgery		
• Facility services	100%	80% of MRC, after deductible
• Professional services	100%	80% of MRC, after deductible
Urgent Care	100%	100% of MRC

	IN NETWORK The Plan Will Pay	OUT-OF-NETWORK The Plan Will Pay
Emergency Care		
• Includes ambulance services when medically necessary	100%	100% of MRC
• First Aid for injuries-for services received within 72 hours after the accident	100%	100% of MRC
• In a doctor's office or other ambulatory facility	100%	100% of MRC
• Hospital Emergency Room Visit	100%, after a $100 deductible. Deductible is waived if re-routed from Urgent Care facility for hospital services or admitted as inpatient or "under observation" at a U.S. hospital.	100%, after a $100 deductible. Deductible is waived if re-routed from Urgent Care facility for hospital services or admitted as inpatient or "under observation" at a U.S. hospital.*
*Immediate hospital admissions through the emergency room, either as inpatient or "under observation" at an out-of-network U.S. hospital, are also covered at 100%.		
Lab & X-Ray Services		
• Inpatient at a hospital	100%	80% of MRC, after deductible
• Outpatient at a hospital	100%	80% of MRC, after deductible
• At a lab and x-ray facility*	90%	80% of MRC, after deductible
• At a doctor's office	90%	80% of MRC, after deductible
Mammograms are covered at 100%, regardless of the place of service or whether they are preventive or diagnostic.		
	IN NETWORK	OUT-OF-NETWORK

*If any of these services are related to an annual physical exam, they are covered at 100%.

	The Plan Will Pay	The Plan Will Pay
Outpatient Short-Term Rehabilitation		
• Medical necessity review required after 30 visits per calendar year	90%	80% of MRC, after deductible
Acupuncture	90%	80% of MRC, after deductible
Applied Behavioral Therapy (ABA)	90%	80% of MRC, after deductible
When medically necessary: $40,000 annual limit per child for dependent children under 19 years of age. Plan members should contact the administrator to ensure understanding and criteria of medical necessity before obtaining these services.		
Kidney Dialysis	90%	80% of MRC, after deductible
Home Health Aides, Skilled Home Health Care Nursing Services, Skilled Home Private Duty Nursing Care	90%	80% of MRC, after deductible
Covered for up to 40 days per calendar year total for any combination of the listed services, if deemed medically necessary under a provider's written Home Health Care Plan or Physician's Care Plan which includes clinical notes/progress notes. Assessment for continuation of any of the above services also requires submission of the foregoing documentation. Any continuation of services beyond 40 days per calendar year must be reviewed for medical necessity supported by clinical information from the provider.		
Hospice		
• Hospice, semi-private (SP) room	100%, (based on negotiated rate)	80% of MRC, after deductible (up to SP rate limit)
• Hospice, private room	100%, (based on SP negotiated rate)	80% of MRC, after deductible (up to SP rate limit)
	IN NETWORK	**OUT-OF-NETWORK**

	The Plan Will Pay	The Plan Will Pay
Organ Transplants (Includes all medically necessary non-experimental transplants)		
• Inpatient facility	100%	80% of MRC, after deductible (up to SP rate limit)
• Semi-Private (SP) room	100%, limited to negotiated rate	80% of MRC, after deductible (up to SP rate limit)
• Private room	100%, limited to SP negotiated rate	80% of MRC, after deductible (up to SP daily rate limit)
• Intensive care unit (ICU)	100%, of negotiated rate	80% of MRC, after deductible (up to ICU limit)
• Physician (surgical) services	100%	80% of MRC, after deductible
• Inpatient visits/consultations	90%	80% of MRC, after deductible
Durable Medical Equipment	90%	80% of MRC, after deductible
External Prosthetic Appliances	90%	80% of MRC, after deductible
Maternity		
• Initial visit to determine pregnancy	90%	80% of MRC, after deductible
• Delivery (includes all subsequent prenatal and postnatal visits)	100%	80% of MRC, after deductible
• Hospital (includes birthing centers)	100%	80% of MRC, after deductible
Abortion (Includes elective or non-elective procedures for any eligible family member)		
• Office visits	90%	80% of MRC, after deductible
• Inpatient facility	100%	80% of MRC, after deductible
• Outpatient facility	100%	80% of MRC, after deductible
• Physician's (surgical) services	100%	80% of MRC, after deductible
	IN NETWORK	**OUT-OF-NETWORK**

	The Plan Will Pay	The Plan Will Pay
Family Planning		
• Office visits for preliminary tests and counseling	90%	80% of MRC, after deductible
• Surgical sterilization procedures (for vasectomy/tubal ligation, including reversals of the same)	100%	80% of MRC, after deductible
Infertility Treatment when Medically Necessary (Lifetime maximum of $50,000–Split $30,000 Medical Services, $20,000 Prescription Drugs)		
• Office visits (including tests and counseling)	90%	80% of MRC, after deductible
• Surgical procedures for infertility (including AI, IVF, GIFT, ZIFT, etc.).	100%	80% of MRC, after deductible
Members contemplating infertility treatment should contact the applicable plan administrator to confirm that medical necessity criteria are met.		
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 MRC, after deductible

2.3 COVERED MEDICAL SERVICES

- **Routine Preventive Care Benefits.** You and your covered dependents are eligible for routine preventive care benefits (for example, standard annual physicals, including standard laboratory tests and immunizations).
- **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 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 Table of Covered Medical Services.)
- **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.
- **Mental health services.** Charges made by a licensed facility for care and treatment of mental illness on an outpatient or inpatient basis. After 45 days of inpatient stay, medical necessity review is required.
- **Treatment of alcohol and drug abuse.** Charges made by a facility licensed to furnish treatment of alcohol and drug abuse for care and treatment provided on an outpatient or inpatient basis. After 45 days of inpatient stay, medical necessity review is required.
- **Physician and other fees.** Charges made by a physician or other licensed health care providers for professional services.
- **Professional nursing services.** Charges made by a nurse for professional nursing services.
- **Anesthetics.** Charges made for anesthetics and their administration.
- **Lab tests and X-rays.** 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 plan 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 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. After 30 days of treatment, medical necessity review is required.
- **Applied Behavioral Therapy (ABA).** Charges for ABA when determined to be medically necessary for the treatment of autism for dependent children under the age of 19, with annual limit of $40,000 per child. Services are subject to periodic review for continued medical necessity.

- **Organ transplants.** Charges made for or in connection with approved organ transplant services, including immune-suppressive medication, organ procurement cost, donor's medical costs, and transportation up to a limit of $10,000 per case only at the in-network level. 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 therapeutic contact lenses following cataract surgery.
- **Home Health Care.** Charges made by a home health care agency for the following medical services and supplies when determined to be medically necessary and provided under a provider's formal, written 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 and prescription drugs dispensed only under a 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.

Please note that these services are covered for up to 40 days per calendar year total for any combination of the cited services. Any continuation of services beyond 40 days per calendar year must be reviewed for medical necessity.

- **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 plan administrator's established criteria.
    - By a hospice facility for services provided in the home.
    - By a physician for professional services.
    - For pain relief treatment, including prescribed drugs 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 or investigational procedures or treatment methods not approved by relevant national authorities or medical specialty societies (e.g., Food and Drug Administration (FDA) or the American Medical Association (AMA) in the U.S. for drugs and medical procedures, respectively) or which are not in accordance with the assigned plan administrator's established standards (i.e., as reflected in its published Clinical Policy Bulletins or coverage policy documents).
- 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; (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 a dependent 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 of the Program.
- **Home Health Care.** The following expenses for medical services and supplies of a home health care agency are not included as covered expenses:
  - Home health care visits in excess of 40 during a calendar year, for all categories of home health care collectively, unless determined to be medically necessary and to be provided under a provider's formal written home health care plan for the person named in that plan.
  - 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.
  - The Medical Plan does not cover long-term care services, whether provided in the home or in a facility, that are custodial in nature. Custodial care consists primarily of assistance with activities of daily living (ADLs), such as personal hygiene, dressing, eating, maintaining continence, and transferring.
- **Hospice Care.** The following expenses for hospice care services are not included as covered expenses:
  - Any period when you or your eligible 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 eligible dependent in the activities of daily living; or
  - To the extent that any other benefits are payable for those expenses under the plans Table of Cover Medical Services;
- 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 on

General Limitations and Exclusions.

2.5 GUARANTEE OF PAYMENT (GOP)

For members residing outside of the U.S. or Puerto Rico, Cigna Global has established a process to issue a Guarantee of Payment (GOP) for any provider or hospital so you may receive necessary services without the need to pay out of pocket and file a claim. The GOP establishes arrangements for Cigna Global to pay a provider directly for services rendered. Please note that out-of-network providers may or may not accept the GOP. If they do not accepted it, you will have to pay and submit a claim to Cigna Global to be reimbursed for what you paid.

The GOP establishes the procedures/services to be rendered, the amounts to be paid, and the service provider who will receive payment. A member or the member's authorized representative should request the GOP prior to a scheduled hospitalization/surgery or other costly procedure.

Although many Cigna Global network providers may not require a GOP, it is always appropriate to request a GOP in advance of scheduled services, especially if there is uncertainty whether the provider is in-or out-of-network for Cigna Global, or if the services required are medically necessary and eligible under the Plan.

A GOP typically should be granted by Cigna Global within 48 hours after the request has been made, except in case of an emergency, when a GOP should be issued within two (2) hours if requested by phone. In the case of planned procedures, it is advisable to request the GOP 14 days before the procedure is scheduled to take place.

If you are based in the U.S. or Puerto Rico, call the number on the back of your Cigna Healthcare card for assistance with a GOP if you need medical services while you are traveling outside the U.S. or Puerto Rico.

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 administrators 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 case management is voluntary, but it can provide help with finding the right resources and obtaining the right treatment when you and your family may need it most.

2.6.2 CASE MANAGEMENT COST

The plan administrators provide this service at no cost to you.

2.6.3 HOW TO USE THE SERVICE

You, your authorized representative, or your doctor can start the process by calling the applicable plan administrator to discuss your particular situation. The plan administrator will then determine if a Case Manager is recommended and/or appropriate.

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 front or back of your ID card.

2.7 MEDICARE OVERVIEW

Participation in Medicare Part B is mandatory under the IDB Group Medical Benefits Program for eligible members. Medicare is the hospital and medical insurance program sponsored by the U.S. Government. You and your dependents are eligible and must enroll in Medicare at age 65 (or three months prior to your 65th birthday) if you meet one of the criteria below:

U.S. citizens or U.S. permanent residents who have worked for at least 10 years in the U.S. before entering the IDB Group, and paid U.S. taxes during that period must register for Medicare Parts A and B. Please note that there is no premium for Medicare part A for these two groups.

Permanent Residents (green card holders) who held a G4 visa at the time of retirement from the IDB Group and meet the requirement of five (5) years of continuous residency in the U.S. must register ONLY for Medicare Part B. **Please note that time spent in G4 visa status qualifies toward the 5-year Medicare residency requirement.**

Medicare Part A pays a portion of the cost for care in hospitals, skilled nursing facilities, hospices, and for some home health care at no cost. Again, there is no premium for Medicare Part A for eligible members.

Medicare Part B pays a portion of the cost for doctors' charges, outpatient hospital care, and some other medical services that Part A doesn't cover. There is a monthly premium cost for Medicare Part B, which will be reimbursed to you by the IDB Group.

Please note that if you do not enroll when you first become eligible, you may have to pay a late enrollment penalty, and you may have to wait until the next annual Medicare General Enrollment Period to do so. This period runs from October 15 to December 7 every year.

When you receive your Medicare ID card, you must send a copy of it to HRD/INS so your Medicare status can be properly recorded.

If you are a U.S. citizen who has begun receiving a monthly Social Security payment from the U.S. government, your Medicare Part B premium is deducted from that payment each month. If you are not collecting Social Security payments, you will receive a quarterly invoice for the Part B premium directly from Medicare.

2.7.1 HOW TO ENROLL IN MEDICARE

AT AGE 65 (OR 3 MONTHS PRIOR TO YOUR 65TH BIRTHDAY):

- If you are a U.S. citizen or a U.S. resident who has worked in the U.S. for at least ten years before entering the IDB Group, and paid U.S. taxes during that period, you must enroll in Medicare Part A (for which there is no premium) AND Medicare Part B.
- If you have permanent resident status, you should enroll only for Medicare Part B. Permanent residents should NOT enroll in Medicare Part A, even if a Social Security representative advises that you may enroll and pay a premium for Part A. You do not need Part A, and you will not be reimbursed for any Part A premium cost.

IDB Group Plan members should NOT purchase Medicare Part C ("Medicare Advantage" plan). You do not need this coverage. The Medical Benefits Program provides the coverages that are included in a Medicare Advantage plan. Members will not be reimbursed for any Medicare Advantage premium cost.

IDB Group Plan members should NOT enroll in Medicare Part D (pharmacy drug program). You do not need this coverage and you will not be reimbursed for any Medicare Part D premium cost.

You may register for Medicare by calling the main Social Security Administration (SSA) office at 1-800-772-1213 to make a telephone or in-person appointment or by making a phone or in-person appointment at an office near your home. You may locate your local SSA office phone number under "Zip Code look up" on the Social Security website at www.SSA.gov.

Online enrollment is also available; however, If you changed from G4 visa status to permanent resident status when you retired from the IDB Group, you MUST request a telephone or in-person appointment because the Social Security online registration system does not accept your actual length of time as a permanent resident to allow the registration process to be completed. If you are a permanent resident and the Social Security representative you speak with does not accept your information regarding the time in G4 visa status as applicable to the 5-year residency requirement, you should ask for the name, office location and phone number of the agent and advise HRD/INS so you can be provided with a formal letter that documents the G4-to-permanent resident status to support the registration process.

U.S. citizens enrolling online should make certain that they are applying ONLY for Medicare benefits, and not for Social Security pension benefits, unless they plan to start receiving their Social Security benefits at age 65 also. PLEASE NOTE that most U.S. citizens are not eligible to receive their full amount of Social Security benefits until age 67 or later. Registering for Social Security pension benefits is a separate process with specific rules and requirements. You should review these carefully if you are or will be eligible to receive Social Security benefits in the U.S.

2.7.2 REIMBURSEMENT OF MEDICARE PART B PREMIUMS

The Bank will reimburse you for the cost of the Medicare Part B premium(s) for you and for your eligible dependents. To receive reimbursement, you must complete the following steps:

- You must provide your Medicare identification number and those of your eligible dependent(s) to HRD/INS as soon as you receive them.
- A member of the HRD/INS team will collect the Social Security number(s) of your eligible dependents (spouse, parent, children) via telephone and will immediately upload it to your records. No physical copy of your Social Security card will be obtained, and no secondary record of it will be retained by the Wellbeing and Health Benefits Team in HRD. A record of the Social Security number is required in order for the Bank to obtain a Medicare subsidy from the U.S. Government which partially covers the premium reimbursement to you.
- Upon receipt of this information, HRD/INS will register you in the IDB Group system as eligible to receive the Medicare Part B premium reimbursement and will send you the Reimbursement Request Form.
- The IDB Group has contracted P&A Group, an external firm, to administer the Medicare Part B reimbursement process on behalf of the IDB Group.

REIMBURSEMENT PROCEDURES

Monthly Reimbursement

To receive monthly reimbursement, you are required to send the P&A Group a completed request form for yourself and a separate form for your eligible dependent(s), if applicable, along with a copy of the letter you receive annually from the Social Security Administration showing the amount of your premium for the coming year, if you are receiving monthly Social Security payments; or a copy of the quarterly "Medicare Premium Bill," (if you do not receive Social Security benefits) which indicates your current year Medicare Part B monthly or

quarterly premium. You should not send a copy of your Medicare card to P&A Group.

You may send your reimbursement request by mail or fax to the following address:

P&A Group–Flex Department
Attn: IDB Group Premium Reimbursement
17 Court Street, Suite 500
Buffalo, NY 14202
Tel: (716) 463-2541
Fax: 1-855-362-7711

You may also set up an online account on the P&A Group website and submit your documentation online at:

www.padmin.com

Reimbursement in Advance

HRD/INS has established a special program with the P&A Group that is available ONLY to members who receive quarterly Medicare premium invoices, and who will never receive Social Security benefits (applicable to most former G4 visa holders). These members have the opportunity once annually to enroll in a pre-paid debit card program through the P&A Group. Once this election has been made, it can only be changed at the next annual enrollment period. Please contact HRD/INS for information about how and when to register for this program.

Important: If you (or your dependent) do not enroll in Medicare Part B when you are eligible, you will have lower reimbursements on your claims for medical services. You will be reimbursed as if you were enrolled in Medicare Part B, meaning that the portion of your costs that would have been covered by Medicare will be deducted from your reimbursement. Processing of your claims may also be delayed or your claims may be denied.

2.7.3 WHERE TO FIND MORE INFORMATION

The U.S. Government sponsors a toll-free number, 1-800-MEDICARE (1-800-633-4227). Once you are connected, you can initiate the enrollment process if you are a U.S. citizen, 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.

2.7.4 COORDINATION WITH MEDICARE MEDICAL BENEFITS

As soon as you are enrolled in Medicare, it is very important that you give both your Medicare ID card and your Cigna Healthcare ID card to each of your providers, and advise the provider that Medicare is your primary insurer or "first payer" and your IDB Group plan is your secondary insurer or "second payer." This will allow your in-network providers to submit your claims properly.

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

The IDB Group 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 will reimburse any allowed expenses at the plan's standard levels of coverage.

Please note that if you are a Cigna Global member with Medicare and you receive medical care in the U.S. or Puerto Rico, please include the Medicare Explanation of Benefits when submitting your claim for the remaining amount with Cigna Global, and clearly indicate that you are eligible for Medicare coverage.

2.7.5 USING NON-PARTICIPATING

MEDICARE PROVIDERS

Most U.S. providers participate in the Medicare program. If you are Medicare-eligible but your provider doesn't participate in the Medicare program, the IDB Group Medical Plan reimburses your eligible expenses as if you were not also covered under Medicare. There are a number of different scenarios that may occur in submitting claims and paying your providers when you have Medicare, depending on: (a) whether your provider is in-network or out-of-network for Cigna Healthcare; (b) your provider is non-participating in Medicare for some or all services; or (c) your provider has "opted out" of Medicare altogether.

It is very important that you advise all of your U.S. providers, including doctors, hospitals and other health care providers, that Medicare is your "first payer," and Cigna Healthcare is your "second payer," so your providers will file your claims correctly and the process called "Coordination of Benefits" can occur, allowing Cigna Healthcare to pay the proper amount remaining after Medicare has paid its authorized amount for covered services.

When you use providers that are in-network with Cigna Healthcare and that are also participating providers with Medicare (these providers "accept Medicare assignment"), your claims should be filed electronically by your provider with no issues, if you have provided the payer information noted above in the proper order. If you have a coinsurance amount applicable to the type of service you receive, your provider will typically collect this at the time of your appointment.

If you use providers that are in-network with Cigna Healthcare and that participate with Medicare for some services but are non-participating with Medicare for certain other services, the provider should still file your claim electronically with both Medicare and with Cigna Healthcare. Providers may selectively choose to participate with Medicare for individual services they provide based on the CPT (Current Procedural Terminology) Code of each service, so you may find that your provider "accepts Medicare assignment" for some services but is "non-participating" for other services. You may also have a coinsurance amount due to your provider, depending on the type of service you received, if your provider did not collect it at the time of your appointment.

If you use providers that are out-of-network for Cigna Healthcare, but are participating with Medicare, you will receive an Explanation of Benefits (EOB) from Medicare showing what Medicare paid to the provider after the provider files electronically with Medicare. In this case you MUST send the Medicare EOB to Cigna Healthcare along with your claim form and invoice/ documentation in order to receive reimbursement for the balance you are owed after Medicare has paid its portion of the bill and you have paid your provider for the balance. Cigna Healthcare has no way of knowing what the Medicare payment was in this case, nor will Cigna Healthcare directly receive the Medicare EOB. Therefore, you are required to submit it with your claim. In this scenario, your provider may, as a courtesy, also file your claim electronically with Cigna Healthcare, although the provider is not required to do so. If this occurs, Cigna Healthcare will hold your claim pending receipt of the Medicare EOB from you. You should receive a notice from Cigna Healthcare that "more information is needed" to pay your claim, requesting that you provide a copy of the Medicare EOB. You may also have a coinsurance amount due to your provider, depending on the type of service you received, if your provider did not collect it at the time of your appointment.

If your provider is in-network with Cigna Healthcare but has "opted-out" entirely from Medicare – meaning that the provider does not accept Medicare in any case, your provider will file your

claim with Cigna Healthcare and will send a copy of his/her Medicare "opt-out letter" along with your claim. Cigna Healthcare will process your claim, minus any applicable coinsurance amount, as an in-network claim.

When your provider is out-of-network with Cigna Healthcare and has opted-out from Medicare, you must pay your provider the full amount you owe and then file your claim for reimbursement with Cigna Healthcare. You MUST ask your provider for a copy of his/her Medicare "opt-out Letter" to file with your claim for reimbursement, as Cigna Healthcare will have no information on your provider's Medicare status.

The chart below summarizes the various scenarios for claim submission with Medicare.

Situation	Action	Payment
Your provider is in-network and participates with Medicare ("accepts Medicare assignment")	Your provider will electronically file your claim with Medicare, and it will be automatically passed to Cigna Healthcare	**Pay only coinsurance, if any, at time of service** Medicare pays its approved portion directly to the provider and Cigna Healthcare pays the remaining balance directly to the provider. If you had an applicable coinsurance and did not pay it out of pocket at the time of your appointment, you may receive a bill from your provider for that amount.
Your provider is in-network, but is non-participating with Medicare for certain services and is participating for other services. (This means your provider chooses not to accept the Medicare negotiated rates for some services, but does accept them for others.)	Your provider will electronically file your claim with Medicare, and it will be automatically passed to Cigna Healthcare	**Pay only coinsurance, if any, at time of service** For the services for which your provider is non-participating in Medicare, Medicare will send you a check for its approved portion for any "non-participating" services and Cigna Healthcare will then send you a check for the remaining balance. ***YOU MUST PAY THESE AMOUNTS TO YOUR PROVIDER.*** For services for which your provider does participate with Medicare, Medicare pays its portion directly to your provider and Cigna Healthcare pays the remaining balance directly to your provider. If you had an applicable coinsurance and did not pay it out of pocket at the time of your appointment, you may receive a bill from your provider for that amount.

Situation	Action	Payment
Your provider is in-network but has "opted out" of Medicare	Your provider will electronically file your claim with Cigna Healthcare and will include his/her Medicare "opt out" letter when filing	**Pay only coinsurance, if any, at time of service** Cigna Healthcare will pay the provider directly; minus any applicable coinsurance you may have. If you had an applicable coinsurance and did not pay it out of pocket at the time of your appointment, you may receive a bill from your provider for that amount.
Your provider is out-of-network for Cigna Healthcare but does participate in Medicare	Your provider will electronically file your claim with Medicare ONLY, and you must file a claim directly with Cigna Healthcare for the balance after Medicare pays OR	**Payment at time of service depends on provider** You will receive a Medicare "EOB" showing the amount Medicare paid to your provider. You must send the Medicare EOB to Cigna Healthcare along with your claim for the balance owed.
	Your provider will electronically file your claim with Medicare and as a courtesy MAY choose to also file your claim electronically with Cigna Healthcare	In this case, Cigna Healthcare will not process the claim from the provider until you provide Cigna Healthcare with a copy of the Medicare EOB you received. Cigna Healthcare has no way of obtaining this Medicare information, so Cigna Healthcare will pend your claim for "more information" and will send you an EOB asking for you to send the Medicare EOB so the balance of the claim can be correctly paid to the provider.
Your provider is out-of-network for Cigna Healthcare and does not participate in Medicare (has "opted out")	Your provider MAY file your claim with Cigna Healthcare as a courtesy, along with a copy of his/her Medicare opt-out letter, but is NOT OBLIGATED to do this.	**Payment at time of service depends on provider** Cigna Healthcare will pay the allowable amount of the claim directly to the provider, less any applicable co-insurance/co-pay.
	Your provider chooses not to file claims with any insurance/payer at all	In this case you must pay your provider out of pocket and file a claim for reimbursement with Cigna Healthcare yourself. In this case, you MUST request a copy of your provider's Medicare opt-out letter to file with your claim.

SECTION 3

PRESCRIPTION DRUG PLAN

SECTION 3. PRESCRIPTION DRUG PLAN

If you are based in the U.S. or Puerto Rico, your prescription drug benefit for prescriptions filled in the U.S. or Puerto Rico is administered by Express Scripts. If you get a prescription filled outside the U.S. or Puerto Rico, you will pay for the prescription and file a claim with Cigna Healthcare for reimbursement.

If you are based in the U.S. or Puerto Rico, when you fill prescriptions at a pharmacy within the Express Scripts network, you will show your Express Scripts ID card. You will be charged the applicable co-pay shown in the chart below in this Section.

If you are based outside the U.S. or Puerto Rico, your prescription drug benefits are administered by Cigna Global. For prescriptions filled in any country outside the U.S. or Puerto Rico, you will pay for your prescription and file a claim with Cigna Global for reimbursement. You will be reimbursed for the cost of the prescription, less the standard $5.00 co-pay for up to a 30-day supply. If you fill prescriptions while in the U.S. or Puerto Rico, you will use your Cigna Global ID card to purchase prescriptions at any pharmacy within the Express Scripts network. Cigna Global accesses the Express Scripts pharmacy network in the U.S. You will be charged the applicable co-pay shown in the chart below for prescription drugs filled in the U.S. Most major U.S. pharmacy chains are part of the Express Scripts network used by Cigna Global. If you use a pharmacy that is not in the Express Scripts network, you will be required to pay for your prescription and file a claim for reimbursement with Cigna Global.

3.1 HOW THE PRESCRIPTION DRUG PLAN WORKS IN THE U.S. OR PUERTO RICO

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 active 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-name drug when a generic equivalent is available, your prescription costs will be higher. You will pay the generic co-pay plus the difference in cost between the brand-name and the generic drug.

The exception to the mandatory generic substitution rule occurs only when your provider indicates on the prescription form that the pharmacist should dispense the prescription exactly as written, i.e., for a brand-name drug. To do this, providers often use the term, "DAW" or "dispense as written."

3.2 PURCHASING YOUR PRESCRIPTIONS BY MAIL ORDER

If you are based in the U.S. or Puerto Rico, Express Scripts Home Delivery Pharmacy (U.S. 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, or to treat other chronic conditions). When you use Express Scripts Home Delivery Pharmacy, you will typically receive up to a 90-day supply of maintenance medications. Please note that these medications can also be dispensed for up to a 90-day supply at retail pharmacies.

To use the mail order option, contact Express Scripts Home Delivery Pharmacy at 1-855-521-0824, or initiate home delivery on the Express Scripts' website.

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.

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, 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 TABLE OF PRESCRIPTION DRUG BENEFITS

Filled in the U.S. or Puerto Rico	Co-pay Retail 30-day supply*	Co-pay Mail-order 90-day supply**
Tier Co-pay		
Generic	US$5	US$10
Formulary (preferred) Brand	US$15	US$30
Non-Formulary (non-preferred) Brand	US$30	US$60
Specialty	US$40	US$80

*Co-pay for a 90-day supply at a retail pharmacy is three (3) times the "Co-pay Retail 30-day supply" stated above per tier.

**US$0 mail order co-pay in the U.S. or Puerto Rico for generic and preferred brands on the Express Scripts Preventive Drug list of drugs for chronic conditions, such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack, stroke, smoking cessation, malaria, obesity, prenatal nutrient deficiency and other chronic conditions. Contraceptives are also covered at US$0 co-pay at mail order.

Lifetime maximum for Infertility drugs is US$20,000.

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

If you fill a prescription at an out-of-network pharmacy in the U.S. or Puerto Rico, you must pay for your prescription at full cost and file a claim for reimbursement with Express Scripts. Please note that you will be reimbursed for only 50% of the amount you paid for the prescription.

Filled outside the U.S. or Puerto Rico	Co-pay Retail 30-day supply	Co-pay Mail-order 90-day supply
Co-pay	US$5	N/A

Lifetime maximum for Infertility drugs is $20,000.

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

If you are based in the U.S. or Puerto Rico and you will be traveling for an extended periods of time, you can contact Express Scripts and ask for a vacation override in order to obtain more than a 90-day supply of your medication.

3.4 WHAT IS NOT COVERED

The Prescription Drug Plan does not pay for:

- Experimental drugs or substances not approved by the relevant national authorities where your treatment occurs (e.g., the Food and Drug Administration (FDA) in the U.S.).
- Drugs labeled, "Caution – Limited by Federal/ National Law to Investigational Use".
- Over-the-counter drugs.
- Prescription vitamins, except prenatal vitamins, certain vitamins that are part of cancer treatment or treatment of other critical medical conditions, and vitamins in prescription-strength dosages when required to treat a major deficiency of those vitamins.
- Herbal or food/nutritional supplements.
- Any medicinal product that 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, pills, and medicines.
- Chinese medicine.
- Cosmetic prescriptions.
- Phytotherapy.
- Hair growth stimulants, hair tonics, and special shampoos.
- Special toothpastes.

3.5 SPECIAL PROGRAMS

Certain very high-cost gene therapy drugs are covered under the Embarc program. a special program that must be coordinated with Cigna Healthcare through the requesting provider. Requests are screened for medical necessity, and the approved drugs under this program must be administered only at Embarc authorized facilities in the U.S.

SECTION 4

VISION PLAN

SECTION 4. VISION PLAN

The Vision Plan provides routine eye care benefits for you and your covered family members. Co-pays for vision services do not apply to the Medical Plan deductible or out-of-pocket maximum.

4.1 HOW THE VISION PLAN WORKS

If you are based in the U.S. or Puerto Rico, your vision benefits are administered by Cigna Healthcare. If you should require vision services outside the U.S. or Puerto Rico while on business or personal travel, you must pay out-of-pocket and file a claim with Cigna Healthcare for reimbursement. Please note that the U.S. in-network maximums will apply for any vision care services and materials you receive outside the U.S. or Puerto Rico, as shown in the second column of Table 4.3.

In the U.S. or Puerto Rico, when you receive vision services at an in-network provider, you will show your Cigna Healthcare ID card. You will be required to pay any applicable co-pay or coinsurance. When you receive vision services at an out-of-network provider, you will pay out-of-pocket for the services you receive and file a claim, with the corresponding prescription and paid invoice, with Cigna Healthcare for reimbursement. Table 4.3 below illustrates the in-network and out-of-network coverage maximums which apply for vision care and materials in the U.S. or Puerto Rico.

Please note that in the U.S. or Puerto Rico, the plan administrator's network of eyewear providers offers exams, eyewear, and contacts at discounted rates. Additional information and a provider directory can be found on the plan administrator website.

If you are based outside the U.S. or Puerto Rico, your vision benefits are administered by Cigna Global. You will pay out-of-pocket for the services you receive and file a claim, with the corresponding prescription and paid invoice, with Cigna Global for reimbursement. **Please note that in the U.S. or Puerto Rico, in-network maximums apply for vision care services and materials, as shown in the second column of Table 4.3.**

Some vision care conditions are covered as medical services. The most common types are cataracts, glaucoma, and conjunctivitis (pink eye). Injuries to the eye are also covered under medical services. For more information, please contact Cigna Healthcare or Cigna Global as applicable.

4.2 FREQUENCY OF YOUR BENEFITS

All of your Vision Plan benefits are offered on a calendar year basis. This means that each calendar year, you will be covered for a new eye exam. It works the same way for frames, prescribed lenses, and prescribed contact lenses.

Once you have used your annual Vision Plan benefits, you must wait until the next calendar year before the plan will pay benefits for the same services again.

4.3 TABLE OF VISION BENEFITS

Benefit	In-network, the plan pays:	Out-of-Network, the plan pays:
Eye Exam	100%, after US$10 co-pay	Up to 70%
Single vision lenses	100%, after US$20 co-pay	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	Up to US$250, no co-pay	Up to US$176
Frames*	Up to US$250	Up to US$120
Frequency**	Every 12 months	

*US$20 co-pay for frames applies only when new frames are purchased to use existing lenses. If the member pays US$20 co-pay for any type of prescription lenses, there is no additional co-pay for frames and the $250 annual allowance for frames applies.
**The 12-month frequency period begins on January 1st (calendar year basis).
Your annual vision benefits includes one pair of prescribed contact lenses or a single purchase of a supply of prescribed contact lenses–in addition to prescribed lenses and frame benefits. (In other words, you may receive prescribed contact lenses and frames/prescribed lenses in the same benefit year).

U.S. and Puerto Rico-based members should call Cigna Healthcare at 1 800-432-3637 with questions about the vision plan or its benefits. Also, you may use the Cigna Healthcare website or the myCigna app to search for in-network vision providers in the U.S. or Puerto Rico.

SECTION 5

DENTAL PLAN

SECTION 5. DENTAL PLAN

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

The types of dental care shown below, provided they are charged at reasonable and customary rates and do not exceed the amounts that would have been charged in the absence of insurance, are covered at different levels under the Dental Plan.

5.1 HOW THE DENTAL PLAN WORKS

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

5.1.1 USING IN AND OUT-OF-NETWORK PROVIDERS

If you are based in the U.S. or Puerto Rico, Cigna Healthcare offers a network of dentists who provide their services at discounted rates. If you use an in-network dentist, your out-of-pocket cost and cost to the Plan may be lower.

If you don't use an in-network dentist, 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) • Periodontal scaling and root planning, and 2 maintenance visits per year following major periodontal service • 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 immediate pain relief, to be followed by referral for further restorative care or oral surgery)	**100%**	**0%**
Basic Restorative Care, such as: • Fillings • Root canal therapy • Denture adjustments and repairs • Simple extractions (not surgical)	**80%**	**20%**

When you need	The Dental Plan pays:	You pay:
Major Restorative Care, such as: • Crowns • Dentures • Bridges • Occlusal Guard Appliances for Bruxism	**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%, and are not subject to the annual benefit maximums, 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 deductibles or 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 (such as braces), 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 is more extensive than routine care, you may request a pre-determination of benefits from the plan administrator so you and your provider will understand whether the services to be provided are typically covered under the plan and what your coverage percentage will be.

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 are considered differently 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 Cigna Healthcare or Cigna Global, as applicable in your case.

5.7 WHAT IS NOT COVERED

The Dental Plan does not pay for:

- Experimental procedures or treatments not approved by the relevant national authorities or specialty societies (e.g., the American Dental Association in the U.S. or Puerto Rico) where your treatment occurs.
- Services performed for cosmetic reasons only.
- Replacement of lost or stolen dental appliances.
- 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 a 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.
- Any services that don't meet the established national and professional standards of dental practices.
- Any services which are covered under the Medical Plan.

SECTION 6

FILING A CLAIM

SECTION 6. FILING A CLAIM

6.1 MEDICAL, DENTAL AND VISION CLAIMS

6.1.1 FOR MEMBERS WHO RESIDE IN THE U.S. OR PUERTO RICO

If you use Cigna Healthcare's network of providers, you will not need to submit a claim because your provider will automatically submit it on your behalf. If you use an out-of-network provider, or if you obtain services outside the U.S. or Puerto Rico, you will need to pay for the services and file a claim for reimbursement with Cigna Healthcare.

For most in-network medical and dental services, you will not be expected to make any payments at the time you receive services, other than the established coinsurance amount. If the provider does not collect the coinsurance amount at the time of service, of if any portion of your claim is not covered by the IDB Group Medical Benefits Program, you will receive an invoice from your provider after the plan administrator and Medicare where applicable, have paid the provider. Out-of-network providers will require you to pay for services out of pocket and file a claim for reimbursement.

You may submit a medical claim through the myCigna website on your computer or mobile phone, by e-mail, by fax, or by postal mail. Dental claims may be submitted by fax or postal mail. Vision claims may be submitted via e-mail, or postal mail.

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

No in-network provider should ask you to pay the full cost of services. If this happens, you should ask the provider to contact your plan administrator immediately. Providers should collect only the applicable coinsurance or co-pay amount at the time of service.

6.1.2 FOR MEMBERS WHO RESIDE OUTSIDE OF THE U.S. OR PUERTO RICO

For most routine services, you will need to pay out-of-pocket and file a claim for reimbursement with Cigna Global. You may submit a claim for services you paid out of pocket through the Cigna Health Benefits website, the mobile app, or by postal mail. Claims cannot be filed via email. If your provider operates under a flash-the-card scheme, or has accepted a GOP for services rendered, you will not have to file any claim with Cigna Global. Your only responsibility will be any co-pay or coinsurance, if applicable.

6.2 PRESCRIPTION DRUG CLAIMS

6.2.1 FOR MEMBERS WHO RESIDE IN THE U.S. OR PUERTO RICO

When you use Express Scripts in-network pharmacies, you will not need to submit a claim.

When you use in-network pharmacies, your only charge will be the co-pay that applies to the tier of the medication you are purchasing. See the handbook section titled, "The Prescription Drug Plan" for more details about co-payments.

If you use an out-of-network pharmacy, you must file a claim for reimbursement with Express Scripts. You should be aware that in this case, you will be reimbursed for only 50% of the cost of your prescription.

If you must purchase a prescription drug when traveling outside the U.S. or Puerto Rico, you must

pay out of pocket and file a claim for reimbursement with Cigna Healthcare. You will be reimbursed the cost of the prescription less the standard US$5.00 co-pay for up to a 30-day supply which applies for overseas prescriptions.

6.2.2 FOR MEMBERS WHO RESIDE OUTSIDE OF THE U.S. OR PUERTO RICO

When you purchase prescription drugs, you must pay out of pocket and file a claim for reimbursement with Cigna Global.

You will be reimbursed for the cost of the prescription less the standard US$5.00 co-pay for up to a 30-day supply which applies for prescriptions outside of the U.S. or Puerto Rico.

When filing a claim for reimbursement, always use the member ID number shown on your card, even though some forms may ask 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 calendar year to qualify for payment of benefits. There are no exceptions to this requirement.

6.4 EXPLANATION OF BENEFITS (EOB)/SETTLEMENT NOTE (SN)

For all claims filed by you or by your providers, you will receive an Explanation of Benefits or "EOB" from Cigna Healthcare if you reside in the U.S. or Puerto Rico" or a "Settlement Note" from Cigna Global for members residing outside of the U.S. or Puerto Rico. Your EOB/Settlement Note 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/SN:

- For **Cigna Healthcare**: Call customer service at +1 800-432-3637. You can also review your EOB information on your personal account at my.cigna.com or the myCigna mobile app.
- For **Cigna Global**: Call customer services at +323 293 1859 globally or at the U.S. toll-free phone: +1 800 297 9983. You can also review your Settlement Note information on your personal account at cignahealthbenefits.com or the Cigna Health Benefits mobile app.

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 plan administrator may make a 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 Benefits 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 are not medically necessary.
- Unnecessary care, treatment, or surgery.
- Out-of-network medical plan charges in excess of Maximum Reimbursable Charges (MRC) or 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 Group plans.
- Expenses billed by a hospital that is owned or operated by a National/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, or for education or training services that are not considered medically necessary therapeutic services.
- Expenses related to activities of daily living (ADLs), including but not necessarily limited to:
- 1. Personal hygiene–bathing, grooming and
- oral care;
- Expenses related to activities of daily living (ADLs), including but not necessarily limited to:
- Personal hygiene–bathing, grooming and oral care;}
- Dressing–the ability to make appropriate clothing decisions and physically dress oneself;
- Eating–the ability to feed oneself though not necessarily to prepare food;
- Maintaining continence–both the mental and physical ability to use a restroom; and
- Transferring–moving oneself from seated to standing and get in and out of bed; all of which are considered to be custodial services.
- Expenses that are eligible for reimbursement under a nationally sponsored public health program, or under a plan sponsored by another level of government.
- 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 first come 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) may be liable or legally responsible for expenses incurred by you or your covered dependents. Benefits may also be payable under an IDB Group plan for such expenses.

In this situation, if an IDB Group plan and a third party both pay expenses for you or one of your covered dependents, a process called "subrogation" will take place. Subrogation is a legal process that entitles the

IDB Group plan to recover payments 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 IDB Group may need you to provide any information and paperwork related to the expenses you incurred 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 IDB Group'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 Group plans and also by another outside plan or program – for example, the medical plan of your spouse's employer–the IDB Group plan will "coordinate" benefits with the 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 IDB Group 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 GROUP PLAN IS PRIMARY

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

7.4.4 WHEN AN IDB GROUP PLAN IS SECONDARY

When the benefit determination rules indicate that the IDB Group's plan is secondary, IDB Group'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 IDB Group 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 states 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 stepparent 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 Group 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 has 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 the IDB Group 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 Group 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:

"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 item of expense that is 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 IDB Group of any changes affecting their own eligibility or the eligibility of their dependents 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 IDB Group and with the plan administrators. 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 IDB Group, to compensate the Program for wrongfully-paid amounts; and other processes for the restitution to the Program or the IDB Group, as applicable, for lost amounts. Furthermore, the consequences of misconduct for active staff include disciplinary sanctions and may include the termination of employment.

The IDB Group 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 applicable plan administrator or the IDB Group shall have the right to request repayment upon notification 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 or admitted "under observation" in a U.S. hospital.

Benefit Maximum. A dollar limit that an IDB Group 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 plan administrators provide, 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 you pay, (e.g., 10%) while the Plan pays the remainder.

Continued Stay Review. Process for ensuring that a continued 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.

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

Co-payment or Co-Pay. The fixed amount in dollar terms you pay out of pocket for prescription drug costs, emergency room utilization, or for some in-network vision services.

DAW. Short for "Dispense as Written," an abbreviation providers in the U.S. or Puerto Rico 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) for Cigna Healthcare, or Settlement Note for Cigna Global. A statement you receive from the plan administrator each time you receive 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. In the U.S. or Puerto Rico, a drug that contains the same active ingredients and provides the same therapeutic benefits as an equivalent, higher-cost brand-name drugs. Generic drugs become available when brand-name drug patents expire.

Home Health Care. Care provided by one or more of: Private Duty Skilled Nursing, Intermittent Home Nursing, or Home Health Aides, depending on the medically necessary needs of the patient.

Hospice. A health care facility or service providing medical care and support services to terminally ill individuals and their families, either on an in-patient or home-based basis.

Mail Order. An option available for members of the International Plan residing in the U.S. or Puerto Rico for receiving prescription drugs through the mail. Mail Order prescriptions include up to a 90-day supply.

Maximum Reimbursable Charges (MRC) or Reasonable and Customary (R&C) Charges. The prevailing out-of-network cost for a specific medical plan service within a given geographical area of the United States. For purposes of the IDB Group Plan in the U.S. or Puerto Rico, administered by Cigna Healthcare, **MRC** for any out-of-network service will be determined at 300% of the Medicare rate for that service in the geographical area where the service was provided.

Outside the U.S. or Puerto Rico, where Cigna Global administers the IDB Group program, R&C rates for any service will be determined by the plan administrator based on prevailing costs within each country. When a member residing outside of the U.S. or Puerto Rico seeks professional services from an out-of-network provider in the U.S. or Puerto Rico, a R&C rate will be applied, based on independent third-party pricing databases.

Medical Necessity or "**Medically Necessary**" 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 (as determined by the relevant national authorities and specialty associations, or the relevant plan administrator's coverage policy documents);

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 which benefits only retirees under the international plan 65 years and older who reside in the U.S. or Puerto Rico.

Network. A group of hospitals, doctors, and other health care professionals contracted by a plan administrator 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 is an individual maximum that applies to you. 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 Prescription Drugs Plan.

Preferred Provider Network. In the U.S. or Puerto Rico, a broad network of doctors, hospitals and other health care providers contracted by a plan administrator, that delivers services for set fees, usually at a discount. While you may use any licensed medical provider you choose, your benefits are highest and your out-of-pocket costs are lower when you use in-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 your authorized representative can start the process by notifying the plan administrator.

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

Pre-Existing Condition. Any diagnosed illness, injury, or other condition that you received treatment for before being covered by the IDB Group medical plan. Aapplies to Sponsored Parents only.)

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 Group medical plan. (Applies to Sponsored Parents only.)

Routine Preventive Care. Regular medical plan benefits, including standard annual physical examinations and related laboratory tests 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 Group to recover payment(s) it made for medical plan or long-term disability plan expenses that a third party was obligated to pay.

APPENDIX: REGULATIONS

PE-375 Medical Insurance Program

Number	PE-375-2023-05-ENG	Approval Authority	PRE
Effective Date	May 25, 2023	Publishing Authority	PRE
Administrative Review Date	May 25, 2023	Supporting Documents	N/A
UBR	HRD	Category	Corporate
UBR Coordinator	Maria Jose Ribeiro	Original language	English
ATI Classification	Confidential	Type	Regulation

INTRODUCTION

The purpose of this regulation is to set forth the participation in the Medical Insurance Program provided by the Bank.

INTERPRETATION AND APPLICATION

The Vice President for Finance and Administration (VPF) shall be responsible for the determination of issues that may arise regarding the interpretation of this regulation and its Annexes, as well as deciding upon exceptional cases consistent with the principles established herein. The General Manager of the Human Resources Department (HRD) shall be responsible for its application and for the issuance of any specific instructions implementing the rule such as related handbooks, guidelines, and/or administrative procedures, which shall be available to all staff members.

AUTHORITY

The VPF, 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 VPF 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

For purposes of this regulation, the following applies:

2.1. **Medical Insurance Program ("Program")**: Health plan sponsored by the Bank which includes medical, dental, vision, and pharmacy benefits. The Program may also be referred to as Retiree Medical Insurance Program as defined in PE-375, Annex 2.

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

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

2.4. **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.

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

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

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

2.8. **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.

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

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

2.11. **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.

2.12. **Vesting**: The grant of entitlement to the Retiree Medical Insurance Program on behalf of a participant as established in Annex 1 of this regulation.

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

2.14. **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.

2.15. **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.

2.16. **Premium**: Cost of participation in the Program. The Premium varies depending upon the eligibility class of the participant as defined in this regulation. 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.

2.17. **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 regulation.

2.18. **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 regulation 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 regulation.

2.19. **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.

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

2.21. **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. See Medical Insurance Premiums Table, available on the HRD intranet site under "Benefits".

2.22. **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.

2.23. **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: (a) death of a spouse or domestic partner providing Alternate Coverage; (b) termination of employment of spouse providing Alternate Coverage; (c) legal separation or divorce from spouse providing Alternate Coverage for the dependent children; or (d) 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 regulation 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 2.10 and 2.11.

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 2.23 occurs. This provision does not apply to a dependent parent, whose coverage is regulated by Section 9.

3.2. VOLUNTARY PARTICIPATION

Participation in the Medical Insurance Program will be optional for:

3.2.1. 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.

3.2.2. Children of the staff member or spouse of the staff member who do not qualify as dependent children under PE-360 "Staff and Family Relationships", regardless of whether (a) they reside with the staff member, or (b) are married. Such coverage ceases on the child's 26th birthday.

3.2.3. Individuals mentioned in paragraph 3.2.1 and 3.2.2 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 2.23 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 2.23. 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 child will begin on the effective date on which 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 have a disability, 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

Staff members who terminate employment with the Bank and are eligible to receive a pension under the Bank's Retirement Plan, may participate in the Medical Insurance

[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 regulation.

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 regulation.

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 either (a) for each 12-month period (or fraction thereof) or (b) in monthly payments; in both cases until the effective date of the staff member's retirement.

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 either (a) as a lump sum based on the number of months elected for participation or (b) monthly.

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 regulation.

6.2. ON TERMINATION OF DEPENDENT STATUS

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

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 started.

7.2. This additional thirty (30) day coverage period is at no cost to the staff member, consistent with paragraph 6.3. of this regulation.

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 regulation.

8. PARTICIPANTS TO THE LONG-TERM DISABILITY PROGRAM

8.1. Staff who are placed on long term disability under PE-379 “Long Term Disability Program”, shall continue participation in the Medical Insurance Program along with their dependents, for the duration of the first period pursuant to section 5.1.1 of PE-379.

8.2. The amount that the staff will pay for participation in the Medical Insurance Program during the first period pursuant to section 5.1.1 of PE-379 “Long Term Disability Program” will be the Basic Premium for Active International Staff.

8.3. Vesting criteria and the determination of the applicable medical insurance premiums in relation to the continued participation in the Medical Insurance Program during the second period pursuant to section 5.1.2 of PE-379 are established in Annex 1 of this regulation.

9. PARENT MEDICAL COVERAGE

9.1. Participation under the Parent Medical Coverage as defined in paragraph 2.2 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.

10. SPECIAL PROVISIONS

In 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. The surviving spouse will be eligible to continue participating in the Retiree Medical Insurance Program under the conditions established in Annex 2 of this regulation.

10.2. The corresponding Medical Insurance premium will be computed based on the deceased staff member's date of hire:

10.2.1. In the case of staff hired prior to January 1, 2015, the corresponding medical insurance premium will be computed as if the deceased staff member were fully vested, and his/her surviving spouse will be eligible to continue participating in the Retiree Medical Insurance Program by paying the Basic Premium for Vested International Retirees.

10.2.2. In the case of staff hired on or after January 1, 2015, the corresponding medical insurance premium will be computed as if the deceased staff member had participated in the Program for a period of five (5) years, or the number of years of participation of the deceased staff member in the Program, whichever period is greater, provided that:

a. If the number of years of participation is 20 or greater than 20, the surviving spouse will be responsible for paying the Basic Premium for Vested International Retirees.

b. If the number of years of participation is less than 20, the surviving spouse will be responsible for paying the Basic Premium for Vested International Retirees under the progressive vesting schedule as defined in PE-375, Annex 1, based on

the greater of: (i) the number of years of participation in the Program of the deceased staff member, or (ii) five (5) years.

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 the overpaid 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.

Original Language: English, in the event of discrepancy the English version will prevail.

PE-375 Annex 1, Vesting Criteria for the Retiree Medical Insurance Program

Number	PE-375-A1-2023-05-ENG	Approval Authority	PRE
Effective Date	May 16, 2023	Publishing Authority	PRE
Administrative Review Date	May 16, 2023	Supporting Documents	N/A
UBR	HRD	Section	Corporate
UBR Coordinator	Maria Jose Ribeiro	Original language	English
ATI Classification	Confidential	Type	Annex

INTRODUCTION

The purpose of this Annex is to establish and regulate the criteria for international staff members to be vested for participation in the Medical Insurance Program as retirees. The applicable vesting criteria depends on the staff member´s 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]

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[2] 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] For the sake of clarity, employment with the Bank shall be deemed to include employment with Inter-American Investment Corporation for the purpose of this document.
[2] For the purpose of Bank regulations, normal retirement age has the meaning given to that term in the Staff Retirement Plan documents.

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

Participation in the Medical Insurance Program while on prolonged leave without pay (paying in advance as a lump sum or on a monthly basis, as agreed, the Basic Premium for International Staff on Prolonged Leave without Pay) will count towards vesting criteria in the Retiree Medical Insurance Program.

1.4. MEDICAL INSURANCE WAIVER

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

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 the Ending Enrollment section of regulation PE-375 "Medical Insurance Plan" 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

Participation in the Medical Insurance Program while on prolonged leave without pay (paying in advance as a lump sum or on a monthly basis, as agreed, 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

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 paragraph 2.2.2) or after pension commencement.

2.5. PREMIUM COST

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, or during the allowed 5-month period of continuation in the Medical Insurance Program following termination of employment, which will count toward fulfilling the vesting criteria so long as the monthly premium is paid. In case that the vesting criteria is not reached, staff members will not be allowed to reach such vesting criteria upon pension commencement.

3.3.2. Staff members hired on or after May 16, 2023, whose pension rights have been transferred to the Staff Retirement Plan of the IDB pursuant to any of the agreements for the transfer and continuity of pension rights between the IDB and another international organization (the "Transfer Agreement"): the years of service credited by the Bank for the purposes of the Staff Retirement Plan under the Transfer Agreement will also be considered as years of participation in the Medical Insurance Program. This will apply for the sole purpose of vesting for the Retiree Medical Insurance Program.

3.4. PROLONGED LEAVE WITHOUT PAY

Participation in the Medical Insurance Program while on prolonged leave without pay (paying in advance as a lump sum or on a monthly basis, as agreed, 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 members 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

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 a Progressive Schedule multiplied by the relevant progressive vesting factor. 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.

4. Staff on Long-Term Disability

The following applies to all participants on long-term disability under PE-379 "Long-Term Disability Program":

4.1. Participation in the Medical Insurance Program during the first two years of enrollment into the long-term disability provided by section 5.1.1 of PE-379 Long-Term Disability Program is mandatory, requires payment of the Basic Premium for Active International Staff, and will count for vesting criteria towards the Retiree Medical Insurance Program.

4.2. Former staff who remain on long-term disability beyond the first two years provided by section 5.1.2 of PE-379 Long-Term Disability Program may opt to continue their participation in the Medical Insurance Program paying the Basic Premium for Active International Staff, which will count for vesting criteria towards the Retiree Medical Insurance Program.

4.3 Former staff who remain on long-term disability beyond the first two years provided by section 5.1.2 of PE-379 Long-Term Disability Program and are granted a pension may opt to continue their participation in the Medical Insurance Program paying the premium for retirees according to the vesting criteria provided in sections 1, 2 and 3 of this Annex.

Original language: English, in the event of discrepancy the English version will prevail.

PE-375 Annex 2 Medical Insurance Program for Retirees

Number	PE-375-A2-2023-05-ENG	Approval Authority	PRE
Effective Date	May 25, 2023	Publishing Authority	PRE
Administrative Review Date	May 25, 2023	Supporting Documents	N/A
UBR	HRD	Category	Corporate
UBR Coordinator	Maria Jose Ribeiro	Original language	English
ATI Classification	Confidential	Type	Annex

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

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 decide 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. 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 any other time as deemed by the Bank.

[1] International Bank retirees vested in the Medical Insurance Program include those hired prior to January 1, 2015, and also 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.

2.3.1. 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 it occurs on or after 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 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 have a disability, 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 and applies also to all dependents of the retiree with the same effective date.

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. Enrollment of retirees and their eligible dependents in the Medical Insurance Program ends thirty (30) calendar days following the death of the retiree. In the event there is an

eligible surviving spouse according to Section 5.2, who in turn is qualified for a survivor's pension from the Bank's Retirement Plans, the surviving spouse and any other eligible dependent of the deceased retiree will be covered under the Medical Insurance Program immediately following the retiree's death, and for a transition period of ninety (90) calendar days. Once the survivor's pension is processed and approved by the Bank's Retirement Plan, any corresponding Medical Insurance premiums will be charged retroactive to the start date of the survivor's pension. If the survivor's pension is not granted during the transition period, coverage for the survivor spouse and any other eligible dependent of the deceased retiree will be suspended.

4.4. 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 without a surviving spouse, 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 (either annually as a lump sum or in monthly payments). 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

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. The Bank may request, at its discretion, immediate repayment or allow the retiree to repay overpaid amounts in installments, as appropriate. The Chief of the Compensation, Benefits, and Human Resources Services Division (HRD/COB) has the authority to approve repayment conditions.

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.

Original Language: English, in the event of discrepancy the English version will prevail.