MEDICAL BENEFITS PROGRAM HANDBOOK

Active and Retired Staff | NATIONAL

JANUARY **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)[1] 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 under the Program 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 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. or Puerto Rico, overseas members have access to Cigna Healthcare's broadest preferred provider network and may also choose to use out-of-network providers with no referrals; 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. Also includes 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 to Cigna Global. During this period, you should also expect the arrival of your ID card.

If you need support to find a medical provider, please contact Cigna Global.

The plan 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 outside the U.S. or Puerto Rico, Cigna Global administers your medical, dental, vision and prescription drug services. 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.

1.3 MEDICAL BENEFITS PREMIUMS

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

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

The EW&HB team of the Compensation, Benefits and HR Services Division, supports the IDB Group in the provision of coverage for medical, dental, pharmacy 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 plan administrators that provide services associated with health benefits, and with the insurance carrier that provides the life insurance policies and services for life, accidental 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 member and benefits eligibility, and claims, please contact Cigna Global. Contact information is available under the "Plan Administrators" section of this handbook.

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

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 wellness challenges, as well as well-being related seminars and services.

Facilities. Lactation room (headquarters and country offices, as applicable).

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
Country Office*	Representative
Traveling on official mission*	Mission Chief and/or Representative

*The Representative or Mission Chief should provide a full written report of the incident to the EW&HB team within seven days.

1.6 PLANS ADMINISTRATION

The IDB Group hires external companies or third-party administrators (TPAs) to process claims and provide network access.

The plan administrator of the various plans will depend on the place where you officially reside as an active staff or retired member.

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.

If you live inside the U.S. or Puerto Rico, Cigna Healthcare administers the medical, dental, and vision benefits while Express Scripts administers prescription drug benefit. 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.

Please note:

- You can contact Cigna Global 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 Cigna Global. Contact information is also available on the front of your Cigna Global ID card.

Cigna Global's secure website allows you to submit and view status of claims, access directories of network providers, and request ID cards. They also provide tools to assist you and your family with personal health and wellness.

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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 Phone: +32 3 293 18 59 **U.S. toll-free phone:** +1 800 297 9983 Fax: +32 663 2855 24/7/365 Customer service English, Spanish, French and Portuguese	Cigna Global Cigna, P.O. Box 69, 2140 Antwerpen, Belgium P.O. Box 451989 Sunrise, Florida 33345
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

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 pharmacy benefits is Express Scripts, Inc. If you travel abroad, you will pay for any prescriptions purchased in the country of destination and file a claim for reimbursement with Cigna Healthcare.	www.express-scripts.com	1-855-521-0824 Fax: 1-608-741-5475 24/7/365 Customer service in English and Spanish	Home Delivery Service P.O. Box 66566 St. Louis, MO 63166-6566

1.7 ELIGIBILITY AND COVERAGE

For terms and conditions such as pre-existing conditions (applicable to dependent parents only), eligibility, mandatory and voluntary participation, enrollment, and termination of coverage, please refer to Staff Rule PN-8.03 and its Annexes 1 & 2 in the Appendix of this handbook.

1.8 THE IDB GROUP MOBILE WEB APP

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

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

- **Current medical, dental, vision, and prescription drug benefits,** including coverage, provider networks, how to submit a claim, how to obtain a Guarantee of Payment, tips for using the plans, a glossary of terms, and more
- **Contact information** for the plan administrators, including a direct dial feature and quick access to download their apps
- **Other benefits**, such as the Employee Assistance Program (EAP) and the free second opinion services from Teladoc, and more!

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.

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 and routine care
- Inpatient hospital services
- Outpatient services at hospitals, doctors' offices and other healthcare 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 Cigna Global. Note that if you see in-network providers that accept "Flash the Card" payments directly from Cigna Global, they will file a claim on your behalf, and you will only pay the applicable coinsurance or co-pay amount, if applicable, to the provider.

Members residing outside the U.S. or Puerto Rico should file all reimbursement requests with Cigna Global.

If you need medical services in the U.S. or Puerto Rico, you have access to the Cigna Healthcare provider network (through Cigna Global). If you choose in-network providers, your coinsurance amount is lower and you also save money for the Program. Contact Cigna Global to help you find in-network providers.

If you choose an out-of-network provider in the U.S. or Puerto Rico, you will pay more for your healthcare, including a higher coinsurance percentage. Out-of-network providers are not obligated to check with Cigna Global in advance to see if your service or procedure is medically necessary or otherwise covered under the IDB Group Medical Benefits Program. Therefore, 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 Cigna Global. This means you are at risk of paying in full for a service that is not covered by our Program; or of receiving a "balance bill" that you must pay for a covered service, since our Program will only reimburse you at the established Reasonable & Customary charge (R&C)* for out-of-network services, which may be lower than the invoiced amount.

Please also note that if you receive medical care in the U.S. or Puerto Rico, your claims inside or outside the Cigna Healthcare network will be processed at the coinsurance level that applies for members of the national plan.

The yearly out-of-pocket maximum for members under the national plan is 10% of gross annual salary/pension.

2.1.1 FINDING IN-NETWORK PROVIDERS IN AND OUT OF THE U.S. OR PUERTO RICO

Call the number on the front of your Cigna Global ID card for help in finding network hospitals, doctors, pharmacies, and other health care providers in and out of the U.S. or Puerto Rico. Contact information in Section 1.6.

2.1.2 "FLASH THE CARD" SERVICES

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

*See Section 9: Glossary of Benefit Terms for a definition of R&C.

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 Guarantee of Payment (GOP) from Cigna Global. Refer to Section 2.5.

2.1.3 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."

2.1.4 APPEALS

The Medical Plan provides for two levels of appeal if you disagree with Cigna Global's decision to deny a claim or the provision of a service. The first level of appeal is handled internally by Cigna Global, 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 Settlement Note (SN) from Cigna Global.

2.2 TABLE OF COVERED MEDICAL SERVICES

Lifetime Maximum	**Unlimited**
	The Plan Will Pay
Doctor's Office Visits or Home Visits	
• For Illness	80%
Routine Preventive Care	100%
• 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 Cigna Global.	
• 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.	
Mental Health and Substance Abuse	
• Inpatient (Medical necessity review after 45 days.)	100%
• Physician charges	80%
• Outpatient	80%
Surgery	100%
Second Opinion for Surgery (includes Lab & X-ray)	100%
Pre-admission Testing (up to 7 days prior to surgery)	100%

Lifetime Maximum	Unlimited
	The Plan Will Pay
Inpatient Hospital Facility Services	
• Semi-private (SP) room	100% of negotiated rate
• Private room	100% of (SP) negotiated rate
• Intensive Care Unit (ICU)	100%
• Doctor's visits/Consultations	80%
• Professional services	100%
Outpatient Surgery	
• Facility services	80%
• Professional services	80%
Emergency Care	
• Includes ambulance services when medically necessary	100%
• First Aid for injuries-for service received within 72 hours after the accident	100%
• In a doctor's office or other outpatient facility	100%
• Hospital Emergency Room Visit	100%
Urgent Care	
• Outpatient facilities	100%
Lab & X-Ray Services	
• Inpatient at a hospital	100%
• Outpatient at a hospital	80%
• At a lab and x-ray facility*	80%
• At a doctor's office	80%
* If any of these services are related to an annual physical exam, they are covered at 100%.	
Outpatient Short-Term Rehabilitation	
• Medical necessity review required after 30 visits per calendar year	50%
Acupuncture	50%
Applied Behavioral Therapy (ABA)	50%
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	80%

Lifetime Maximum	Unlimited
	The Plan Will Pay
Home Health Aides/Skilled Home Health Care Nursing Services/Skilled Home Private Duty Nursing Care/Outpatient Private Duty Nursing	50%
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 visits per calendar year must be reviewed for medical necessity supported by clinical information from the provider.	
Hospice	
• Hospice, semi-private room (SP)	100% of negotiated rate
• Hospice, private room	100% of (SP) negotiated rate
Organ Transplants (Includes all medically necessary non-experimental transplants)	
• Inpatient facility	100%
• Semi-private (SP) room	100%, limited to negotiated rate
• Private room	100%, limited to SP negotiated rate
• Intensive care unit (ICU)	100%
• Physician (surgical) services	100%
• Inpatient visits/consultations	80%
Durable Medical Equipment	80%
External Prosthetic Appliances	80%
Maternity	
• Initial visit to determine pregnancy	80%
• Delivery (includes all subsequent prenatal and postnatal visits)	100%
• Hospital (includes birthing centers)	100%
Abortion (Includes elective or non-elective procedures for any eligible family member)	
• Office visits	50%
• Inpatient facility	50%
• Outpatient facility	50%
• Physician's (surgical) services	50%
Family Planning	
• Office visits (including tests and counseling)	80%
• Surgical sterilization procedures (for vasectomy/ tubal ligation, including reversals of the same)	50%

Lifetime Maximum	Unlimited The Plan Will Pay
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)	80%
• Surgical procedures for infertility (including AI, IVF, GIFT, ZIFT, etc.).	100%
Plan members must contact Cigna Global to ensure understanding of and criteria for medical necessity before obtaining these services.	
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
Vision	
• First pair of glasses following a cataract surgery	80%

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, 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 it is warranted.
- **Hospital bed, hospital board, services, and supplies.** Charges made by a hospital for bed and board, and for other necessary services and supplies. Subject to the limits shown in the plan's 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. Cigna Global 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 for in-network facilities. 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 Cigna Global '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. or Puerto Rico for drugs and medical procedures,

respectively) or which are not in accordance with Cigna Global'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 any one of your dependents who is less than 16 years old to correct a congenital anomaly.
- Charges for a second surgical opinion rendered more than six months after a surgeon has first recommended the surgical procedure.
- Charges made for or in connection with 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 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
  - Care or treatment provided in 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 plan's Table of Covered 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, General Limitations and Exclusions.

2.5 GUARANTEE OF PAYMENT (GOP)

Outside 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 accept 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 cases 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.

To request a GOP, contact Cigna Global at the phone number on the front of your ID card.

2.6 MEDICAL CASE MANAGEMENT

If you or one of your covered family members need medical treatment for a serious condition, the case management service offered by Cigna Global 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

Cigna Global provides 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 Cigna Global to discuss your particular situation. Cigna Global 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 of your ID card.

SECTION 3

PRESCRIPTION DRUG PLAN

SECTION 3. PRESCRIPTION DRUG PLAN

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. or Puerto Rico. Most major U.S. or Puerto Rico 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

The Prescription Drug Plan includes coverage for brand-name and generic drugs. In the U.S. or Puerto Rico, 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 patents 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 in the U.S. or Puerto Rico 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."

While in the U.S. or Puerto Rico, you will need to use your Cigna Global ID card to fill prescriptions at network pharmacies. You will only have to pay the corresponding co-payment. To purchase drugs at out-of-network pharmacies in the U.S. or Puerto Rico, you will need to pay their full cost and then submit your claim to Cigna Global for reimbursement. The cost of prescription drugs is higher at out-of-network pharmacies. Please visit the Cigna Global website or download its mobile app to find the pharmacies that are in its network in the U.S. or Puerto Rico.

3.2 TABLE OF PRESCRIPTION DRUG BENEFITS

Filled outside the U.S. or Puerto Rico	Co-pay retail for up to 30-day supply*	Co-pay mail-order for 90-day supply**
Co-pay	US$5	N/A

*The copay for a 90-day supply at a retail pharmacy is three (3) times the "Retail 30-day Supply Copay", which outside the U.S. or Puerto Rico is $5.
**If you reside outside of the U.S. or Puerto Rico, the mail order option is not available because U.S. law does not allow drug sellers to ship prescription drugs abroad.
Lifetime maximum for Infertility drugs is US$20,000.
Lifestyle drugs (e.g., erectile dysfunction, impotence): Limit of 4 pills per month.

Filled in the U.S. or Puerto Rico	Co-pay retail for up to 30-day supply*	Co-pay mail-order 90 day supply
Tier Co-pay		
Generic	US$5	N/A
Formulary (preferred) Brand	US$15	N/A
Non-Formulary (non-preferred) Brand	US$30	N/A
Specialty	US$40	N/A

*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.
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 Cigna Global. Please note that you will be reimbursed for only 50% of the amount you paid for the prescription.

3.3 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. or Puerto Rico).
- Drugs labeled, "Caution – Limited by National / Federal Law to Investigational Use".
- Over-the-counter drugs.
- Prescription vitamins, except prenatal vitamins, certain vitamins that are part of cancer treatment or treatments 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.
- Medicinal foods or medical vitamins available over the counter.
- 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, pill and medicines.
- Chinese medicine.
- Cosmetic prescriptions.
- Phytotherapy.
- Hair growth stimulants, hair tonics, and special shampoos.
- Special toothpastes.

3.4 SPECIAL PROGRAMS

Certain very high-cost gene therapy drugs are covered under the Embarc program, a special program that must be coordinated through Cigna Global, HRD/INS and 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.

4.1 HOW THE VISION PLAN WORKS

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 outside of the U.S. or Puerto Rico, in-network maximums apply for vision care services and materials, as shown in the second column of Table 4.4.

If you require vision services outside of your country of residence, you will pay out of pocket and file a claim with Cigna Global for reimbursement. Please note that in the U.S. or Puerto Rico, in-network maximums apply for vision care services and supplies, as reflected in the second column of Section 4.4.

4.2 FREQUENCY OF YOUR BENEFITS

All 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 receive 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 RECEIVING YOUR BENEFITS

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

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 Global.

4.4 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).
Please note that your benefit each calendar year is one pair of prescribed contact lenses or a one-time purchase of disposable prescribed contact lenses–in addition to the benefit for prescribed lenses and frames. In other words, you will be able to receive prescribed contact lenses and frames with prescribed lenses in the same benefit year.

Please call Cigna Global if you have questions about the vision plan and its benefits, or if you need assistance to find in-network 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

During the first 12 months of participation in the Dental Plan, benefits are limited to 50% reimbursement.

After 12 months of participation and only if the participant has incurred and submitted a claim for reimbursement during the previous 12 months, the Dental Plan will provide the benefits described in the Table of Covered Dental Services.

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

If you need assistance to find network providers in the U.S. or Puerto Rico, please contact Cigna Global.

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)	**80%**	**20%**
Basic Restorative Care, such as: • Fillings • Root canal therapy • Denture adjustments and repairs • Simple extractions (non 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 benefite 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 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$1,500. This limit renews each calendar year. During the first 12 months of participation in the Dental Plan, benefits are limited to 50% reimbursement.

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, it's advisable to request a pre-determination of benefits from Cigna Global to determine Plan coverage and the costs that it will cover. By doing this, you and your dentist will know ahead of time what the dental plan will cover and how much it will pay.

5.5 COVERAGE FOR ACCIDENTAL DAMAGE

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

5.6 WHEN SERVICES BEGIN

In all but a few cases, services begin when your dentist or 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 Global.

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.) 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 tooth; 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 that are covered under the Medical Plan.

SECTION 6

FILING A CLAIM

SECTION 6. FILING A CLAIM

6.1 MEDICAL, VISION, DENTAL AND PRESCRIPTION DRUG CLAIMS

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.

Always use the ID number shown on your ID card, when you submit your claims for reimbursement. Keep copies of your claims and supporting documentation until you or the provider have received the corresponding payment

6.2 DEADLINE FOR SUBMITTING CLAIMS IN A CALENDAR YEAR

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

6.3 SETTLEMENT NOTE (SN)

For all claims filed by you or by your providers, you will receive a "Settlement Note" (SN) from Cigna Global. Your SN will show 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 SN, you can call customer service 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.

6.4 SPECIAL PROVISIONS

6.4.1 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.

6.4.2 IF YOU DIE BEFORE RECEIVING REIMBURSEMENT

In this case, Cigna Global 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.

6.4.3 THE IDB GROUP'S LIABILITY

Payments as described above will release the IDB Group 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 Reasonable and Customary charges (R&C).
- 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 or health facility 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 to care for a member 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;
    2. Dressing–the ability to make appropriate clothing decisions and physically dress oneself;
    3. Eating–the ability to feed oneself though not necessarily to prepare food;
    4. Maintaining continence–both the mental and physical ability to use a restroom; and
    5. Transferring–moving oneself from seated to standing and get in and out of bed; all of which are considered to be custodial services.
- Expenses that are eligible for reimbursement under a nationally sponsored public health program, or 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 payment it made for expenses that a third party was obligated to pay.

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

In its efforts to recover payment, the 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 does 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 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 Group 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, 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:

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

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

"Allowable Expense" means any necessary, reasonable, and customary 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 Cigna Global. 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, Cigna Global 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" status in the 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 Cigna Global provides, designed to ensure you receive the right medical care in the right setting when coping with a serious condition or illness.

Coinsurance. The portion (usually expressed as a percentage) of the total covered benefit costs that you pay (e.g., 50%), while the Plan pays the remainder of the total cost.

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 U.S. dollars a participant has to pay out of pocket when purchasing prescription drugs.

DAW. Short for "Dispense as Written," an abbreviation medical 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 in the US or Puerto Rico.

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

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 drug. 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 that provides medical care and support services to terminally ill individuals and their families, either on an inpatient 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.

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 Cigna Global'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. and Puerto Rico.

Network. A group of hospitals, doctors, and other health care professionals contracted by Cigna Global that provide access to medical care, and in some facilities 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 only. If you are covering yourself and your family members, there is a maximum that applies to all of you. If your eligible expenses exceed these maximums, the plan will pay 100% of the cost for any additional eligible medical plan expenses for the rest of the calendar year, except for service-specific maximums.

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

Pre-Admission Certification. The review and approval process Cigna Global conducts before you enter the hospital for treatment. Your doctor, you, or your authorized representative can start the process by notifying Cigna Global.

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. (Applies to sponsored parents only.)

Preferred Provider Network. In the U.S. or Puerto Rico, a broad network of doctors, hospitals and other health care providers contracted by Cigna Global, 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 in the U.S. or Puerto Rico.

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.)

Reasonable and Customary (R&C). It refers to the prevailing out-of-network cost for a specific medical plan service within a given country.

R&C rates will be determined by Cigna Global based on prevailing costs within each country. Furthermore, when a member of the national plan residing outside of the U.S. or Puerto Rico seeks professional services from an out-of-network provider in a particular geographical area in the U.S. or Puerto Rico, an R&C rate will be applied, and it will be determined by Cigna Global as the 90th percentile of the costs of the service in that area as established in nationally recognized databases utilized by third-party administrators and insurers as the acceptable rate of payment (i.e., limit). This means that, for a specific service, 90% of the providers in the geographic area charge the same or less than the R&C rate.

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.

Settlement Note. A statement you receive from Cigna Global each time you receive medical plan services, showing how submitted charges affect your out-of-pocket maximum, the portion of the submitted charges that were paid by the plan, and what portion (if any) is your responsibility.

Subrogation. A legal process that entitles the IDB Group to recover payments for medical plan expenses on your behalf that a third party was obligated to pay.

APPENDIX: REGULATIONS

PN-8.03 MEDICAL INSURANCE PROGRAM

Effective: August 2017

INTRODUCTION

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

INTERPRETATION AND APPLICATION

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

AUTHORITY

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

1. GENERAL

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

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

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

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

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

2. DEFINITIONS

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

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

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

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

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

2.1.5. Spouse: The person registered with the Bank as the wife or husband; or the domestic partner of the participant as per Staff Rule PN-8.08 "Staff and Family Relationships".

2.1.6. Dependent Children: Children of the participant or the spouse of the participant as established in Staff Rule PN-8.08 "Staff and Family Relationships".

2.1.7. Dependent Parent: Parent or parent-in-law of the participant as established in Staff Rule PN-8.08 "Staff and Family Relationships".

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

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

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

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

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

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

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

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

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

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

2.1.18. Basic Premium for National Staff on Prolonged Leave without Pay: The cost as published by the Bank for staff members who are on extended leave of absence as regulated by Staff Rule PN-8.01-5 "Leave Without Pay". This rate will also be applicable for continued participation in the Program after termination of service, as per paragraphs 6.1.2 or 6.1.3 of this Staff Rule.

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

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

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

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

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

3. PARTICIPATION IN THE MEDICAL INSURANCE PROGRAM

3.1. MANDATORY PARTICIPATION

3.1.1. All national Bank staff with employment contracts defined in Staff Rule PN-5.02 "Types of Appointments", and their respective spouses and dependent children, must participate in the Medical Insurance Program.

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

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

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

3.2. VOLUNTARY PARTICIPATION

3.2.1. Participation in the Medical Insurance Program will be optional for children of the staff member or spouse of the staff member who do not qualify as dependent children for purposes of Bank policy, regardless of whether (a) they reside with the staff member, or (b) are married. Such coverage ceases on the child's 26th birthday.

3.2.2. Individuals mentioned in paragraph 3.2.1 who have decided not to participate in the Program will be allowed to enroll thereafter only if a Qualifying Life Event as described in paragraph 2.1.23 occurs.

4. ENROLLMENT IN THE MEDICAL INSURANCE PROGRAM

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

4.1.1. On the effective date of hire, or

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

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

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

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

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

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

6. ENDING ENROLLMENT

6.1. ON TERMINATION OF EMPLOYMENT WITH THE BANK

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

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

6.1.3. Staff hired on or after September 1, 1995 may continue participating in the Medical Insurance Program beyond the thirty (30) days mentioned in paragraph 6.1, and may continue the participation of their dependents, for an additional five (5) calendar months, provided they pay in advance the Basic Premium for National Staff on Prolonged Leave without Pay.

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

6.2. ON TERMINATION OF DEPENDENT STATUS

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

6.3. AFTER ENDING ENROLLMENT

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

7. STAFF ON PROLONGED LEAVE WITHOUT PAY

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

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

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

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

8. STAFF ON LONG TERM DISABILITY

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

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

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

9. PARENT MEDICAL COVERAGE

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

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

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

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

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

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

10. SPECIAL PROVISIONS

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

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

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

11. MISREPRESENTATION AND FRAUDULENT CLAIMS

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

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

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

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

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

12. RECOVERY OF OVERPAYMENT

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

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

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

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

PN-8.03 ANNEX 1 VESTING CRITERIA FOR THE RETIREE MEDICAL INSURANCE PROGRAM

Effective: August 2017

INTRODUCTION

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

1. STAFF HIRED PRIOR TO SEPTEMBER 1, 1995

1.1. IMMEDIATE PENSION

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

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

1.1.2.1. During this time staff members will have to pay the Basic Premium for Non-Vested National 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 National 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 National 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 National Retirees.

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

1.3. PROLONGED LEAVE WITHOUT PAY

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

1.4. MEDICAL INSURANCE WAIVER

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

1.5. PREMIUM COST

1.5.1. Staff members hired prior to September 1, 1995 will pay the Basic Premium for Vested National Retirees, the Basic Premium for Non-Vested National Retirees, or the Basic Premium for National 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 National 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 National 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 National 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 National 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 PN-8.03 paragraph 6.1.1 will count toward the accumulation of five (5) years of continuous participation in the Program.

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

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

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

2.3. PROLONGED LEAVE WITHOUT PAY

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

2.4. MEDICAL INSURANCE WAIVER

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

2.5. PREMIUM COST

2.5.1. Staff members hired on or after September 1, 1995 and prior to January 1, 2015 will pay the Basic Premium for Vested National Retirees, the Basic Premium for Non-Vested National Retirees, or the Basic Premium for National 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 National 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 National Retirees provided they have had at least twenty (20) years of participation, continuous or non-continuous, in the Medical Insurance Program as an active staff member prior to termination of service.

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

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

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

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

3.3. FULFILLING VESTING CRITERIA

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

3.4. PROLONGED LEAVE WITH OUT PAY

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

3.5. MEDICAL INSURANCE WAIVER

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

3.5.2. For staff who have waived their participation in the Medical Insurance Program, at any time during active service, total periods of participation as an active staff member will count towards vesting for Retiree Medical as established in this Annex.

3.6. PREMIUM COST

3.6.1. Staff members hired on or after January 1, 2015, will pay the Basic Premium for Vested National Retirees, the Basic Premium for National Staff on Prolonged Leave without Pay, or the Basic Premium for National 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 National Retirees under the Progressive Schedule. Staff members follow a progressive schedule in determining the premium amount to be paid upon pension commencement in which the premium amount will be reduced according to the Years of Participation for Vesting in the Medical Insurance Program during active service.

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

3.7.3. Upon pension commencement, the staff member will pay the Basic Premium for National 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.

PN-8.03 ANNEX 2 MEDICAL INSURANCE PROGRAM FOR RETIREES

Effective: August 2017

INTRODUCTION

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

1. PARTICIPATION IN THE MEDICAL INSURANCE PROGRAM

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

2. VOLUNTARY ENROLLMENT

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

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

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

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

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

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

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

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

[1]National Bank retirees vested in the Medical Insurance Program include those who accumulated a minimum number of years of participation in the Program under the progressive schedule as per paragraphs 3.1.2 and 3.2.2 of PN-8.03 Annex 1.V

3. PARENT MEDICAL COVERAGE

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

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

4. ENDING ENROLLMENT

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

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

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

5. SPECIAL PROVISIONS

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

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

5.2.1. If the retiree passes away and the surviving spouse was the spouse of the retired participant on the last day of the retiree's active service, and the surviving spouse continues receiving a pension from the Bank's Retirement Plans, continued participation in the Medical Insurance Program requires payment of the Basic Premium for Vested National Retirees, or the Basic Premium for National 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 National Retirees, or the Basic Premium for National 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 National Retirees.

5.2.3. If the surviving spouse, receiving a pension

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

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

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

6. MISREPRESENTATION AND FRAUDALENT CLAIMS

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

6.2. 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 Cigna Global.

6.3. 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.

6.4. 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.

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

7. RECOVERY OF OVERPAYMENT

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

7.2. 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.

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