



**Inter-American  
Development Bank**

**INTERNATIONAL STAFF  
Insurable Benefits Program Handbook**

**2007**

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## Overview

### About This Handbook

This handbook provides information about the Inter-American Development Bank's ("IDB") Insurable Benefits Program. The program includes coverage for:

- Life Insurance
- Long-term Disability
- Medical
- Prescription Drugs
- Vision, and
- Dental.

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

Throughout the handbook, you'll find "information boxes" with this symbol:  When you see the information symbol, read what's inside the box to learn more about the highlighted topic.

Also you'll find the phrase – "Have a Question?" – at different points in the handbook. When you see that phrase, there will be a question about a particular benefit issue, along with the answer or instructions on where to call for more information.

### Your Benefits at a Glance

Each of the plans included in the Insurable Benefits Program provides comprehensive coverage that's designed to protect you and your family.

The chart on the following page provides a first "glance" at the plans. You'll find more details about each plan in later sections of this handbook.

## Overview

<b>Plan type:</b>	<b>Benefits:</b>
<ul style="list-style-type: none"> <li>▪ Basic Life Insurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ In the event of your death, pays a benefit equal to 1½ times your net annual salary</li> </ul>
<ul style="list-style-type: none"> <li>▪ Basic Dependent Life Insurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ In the event of your spouse's or dependent child's death, pays a benefit of \$10,000 for your spouse and \$3,500 for each of your dependent children</li> </ul>
<ul style="list-style-type: none"> <li>▪ Basic AD&amp;D Insurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ In the event of your accidental death, pays a benefit equal to 3 times your net annual salary</li> </ul>
<ul style="list-style-type: none"> <li>▪ Supplemental Life Insurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ Additional life insurance coverage for you and your spouse in an amount you choose</li> </ul>
<ul style="list-style-type: none"> <li>▪ Supplemental AD&amp;D Insurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ Additional AD&amp;D coverage for you and your family in an amount you choose</li> </ul>
<ul style="list-style-type: none"> <li>▪ Retiree Death Benefit</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provides death benefits for eligible retirees and their spouses</li> </ul>
<ul style="list-style-type: none"> <li>▪ Long-term Disability Insurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ Replaces a portion of your salary if you become totally disabled and unable to work</li> </ul>
<ul style="list-style-type: none"> <li>▪ Medical</li> </ul>	<ul style="list-style-type: none"> <li>▪ Preferred Provider plan, with in-network and out-of-network benefits</li> <li>▪ Covers doctor's office visits, emergency care, hospitalization, preventive care, and many other services</li> </ul>
<ul style="list-style-type: none"> <li>▪ Prescription Drugs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Generic and brand-name prescriptions available at pharmacies nationwide, and through the mail.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Vision</li> </ul>	<ul style="list-style-type: none"> <li>▪ Covers a portion of the expense for eye exams, frames and lenses, or contact lenses.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Dental</li> </ul>	<ul style="list-style-type: none"> <li>▪ Covers the largest portion of the cost of preventive care, diagnostic care, and basic restorative care.</li> <li>▪ Additional benefits for major restorative care and for orthodontics</li> </ul>

In the sections that follow, the handbook describes each of the plans listed above in more detail. Each section highlights a different topic or a particular plan, including charts summarizing all the important plan provisions and administrative details you'll need to know.

### Cost Sharing

IDB shares the cost of the program with employees. IDB pays 2/3rds of the cost, and participants contribute 1/3rd through regular payroll deductions. For supplemental plans (such

## Overview

as some life insurance options, for example), employees electing coverage pay the full coverage cost.

### Administration and Insurance

Most plans (medical, dental, vision, prescription drug, retiree life, and long-term disability) are self-funded. This means that the Insurance Program, rather than an insurance company, pays the full cost of claims. Outside companies (like CIGNA, for example) provide administrative services in connection with the Program.

The life insurance plans (including the supplemental coverages paid for by employees) are fully insured. This means that an insurance company provides coverage under the terms of a policy and collects pre-set premium amounts from the Organization and from employees.

### Eligibility Overview

Participation in the Program is mandatory, with only a few exceptions. If you are able to prove that you're covered under a comparable group medical insurance plan elsewhere, you may decline coverage. Otherwise, in most cases, you need to enroll in the Program when you're first eligible.



The "Eligibility" section of the handbook provides more detailed information about eligibility for you and your dependents, along with other useful information on when coverage under the Program begins, and when it ends.

## Definitions

### *Key Words and Phrases*

You'll find definitions for key words throughout the handbook. Also, at the back of the handbook, you'll find a section called "Glossary of Benefit Terms," bringing together each of the words or phrases you should know which have a precise meaning as they relate to the Program.

#### *The term "You"*

The handbook is a resource for you and your covered family members. Each time you see the word "you," remember that it applies to you and also to your covered dependents.

#### *The term "Spouse"*

Each time you see the word "spouse", remember that it also applies to your registered domestic partner.

## Useful Contacts



This section provides phone numbers and other information on who to call when you have a question about your benefits.

### Contacting CIGNA

CIGNA provides Member Services for the IDB Medical, Prescription Drug, Vision and Dental plans. Call CIGNA any time you need to:

- Know more about how your benefits work
- Check on what's covered under the plans
- Locate a doctor or other provider
- Find out about the status of a claim you've filed.

The following table provides the contact information you'll need for CIGNA.

Your location:	Contact CIGNA by phone:	Contact CIGNA by mail:
If you reside in the U.S.	<b>1-800-742-4136*</b>	CIGNA Healthcare(Medical) P.O. Box 5200 Scranton, PA 18505-5200  CIGNA Healthcare(Dental) P.O. Box 18036 Chattanooga, TN 37422-8036
If you reside outside the U.S	1-800-441-2668 or 1-302-797-3100	CIGNA International P.O. Box 15050 Wilmington, Delaware 19850  <u>Overnight Delivery:</u> 590 Naamans Road Claymont, Delaware 19703

\* When dialing this number you will be prompted to input your ID number and account number that appears on your ID card.

You'll also see your CIGNA member services telephone number on the back of your ID card.

## Useful Contacts

If you need assistance with Spanish-language telephone service, CIGNA can help you. When you call Member Services, just ask for a Spanish-speaking representative.

### Contacting INTRACORP

INTRACORP is a CIGNA affiliate that provides certain services in connection with the Medical Plan, like pre-admission certification for hospital stays, and the CIGNA “Careline.”

*A quick look at pre-admission certification:* If you’re in the U.S. and you need to schedule a hospital stay, call INTRACORP to make sure you receive the highest level of benefits. You, your doctor, a family member, or anyone else who is able to provide basic information about you, can make the call. It’s important to notify INTRACORP because non-certified hospital admissions are subject to a \$400 penalty.

If your upcoming hospital stay will be outside the U.S., you don’t need to call INTRACORP.

*A quick look at the CIGNA Careline:* Careline is a free resource that provides information about a large variety of health-related topics. When you call, you can also speak to a registered nurse who can discuss your problem or situation, offer answers to your questions and direct you to medical care if necessary.

You can reach INTRACORP by dialing the toll-free 800 number on the back of your CIGNA Medical Plan ID card. Once you’re connected, listen to the prompts and select the option you need.



- You’ll find more about pre-admission certification for hospital stays in the section entitled, “The Medical Plan,” page 6.12.
- If you want to learn more about Careline, you’ll find details at Cigna’s website at [www.cigna.com/consumer/services/healthcare/programs/24hour.html](http://www.cigna.com/consumer/services/healthcare/programs/24hour.html).

### Contacting IDB about a Work-Related Illness or Injury

If you’re injured or become ill because of a work-related incident, it’s important that you let IDB know. Even if you think it’s minor, IDB needs to understand what has happened in order to make sure you receive the right benefits.

- During your regular work hours at IDB Headquarters: notify the Supervisor of the Health Unit.
- During off-duty time while at IDB: notify the guard on duty.

## Useful Contacts

- During an official mission or if assigned to a Country Office: notify the Representative or Mission Chief. He or she should provide a full written report of the incident to the Insurance Section within seven days.

### Contacting the IDB Insurance Section

If you need to speak to someone at IDB about your benefits, you can reach the Insurance Section by phone, fax, and by e-mail. Here's the information you'll need:

By phone:	202-623-3137
By fax:	202-623-3305
By e-mail:	HRD/ins
Via the Internet:	HRD/ins@iadb.org

### Web Access

Cigna Health Care and Cigna International have established websites that allow participants to view processed claims, access network directories and request ID cards. The websites also provide tools to assist with your personal health and wellness.

If you reside in the United States, you can access the Cigna HealthCare website at [www.mycigna.com](http://www.mycigna.com). Just follow the prompts to enroll in this free service.

If you work in one of the IDB Country Offices or reside outside the United States, you can access the Cigna International website at [www.cigna.com/cieb](http://www.cigna.com/cieb) and following the enrollment instructions.

## Eligibility

This section provides detailed information about eligibility to participate in the IDB Insurable Benefits Program. Below are details on the eligibility rules that apply to you, along with the provisions for covering your family members under the Program.

### Mandatory Participation

The following individuals are required to participate in the Program (unless covered through another source that is comparable to the benefits provided by the IDB plans):

- Permanent, indefinite and fixed-term employees, their spouses and Bank-authorized dependent children
- Temporary employees with uninterrupted contracts of six months or more (excluding extensions), their spouses and Bank-authorized dependent children

### Optional Participation

Participation in the Insurable Benefits Program is optional for the following individuals:

- Executive Directors, their spouses, and Bank-authorized dependent children
- Alternate Executive Directors, their spouses and Bank-authorized dependent children
- Counselors to the Executive Directors, their spouses and Bank-authorized dependent children
- Directors of the Office of Evaluation and Oversight, their spouses and Bank-authorized dependent children
- Retired employees and surviving spouses receiving a pension from the Staff Retirement Plan and their qualified dependents, and surviving children receiving a Child Benefit from the Staff Retirement Plan
- Temporary Employees — A temporary employee, whose original contract or extension thereafter is for a period of less than six months, can participate in the Insurable Benefits Program starting with the seventh month of uninterrupted service. In this case, participation in the program is **limited to individual coverage only**.
- Employees on Leave Without Pay ---The employee may continue his participation, if the Bank so authorizes, by paying both his and the Bank's quarterly contributions in advance. These payments will be based on the employee's basic salary in effect on the date the leave is initiated.
- Sponsored Children — You may sponsor your single (never-married) dependent children as long as they fulfill the following requirements:

## Eligibility

- They must be less than 25 years of age and if working, their gross annual income must not exceed \$10,000.
  - They must not be eligible for any other type of group medical insurance elsewhere. If necessary, you may be required to provide proof of your dependent's income as well as proof that he or she is not eligible under another group medical insurance program.
  - If you are an active staff member sponsoring a dependent who loses his status as a Bank-authorized dependent, you may request a continuation of participation in the Medical Plan. However, you must submit your request within 30 calendar days from the date on which the status of your dependent changed.
  - If you are eligible to participate in the Insurable Benefits Program, you have 30 calendar days from your date-of-hire to request participation in the Program for your eligible dependents.
- Sponsored parents and parents-in-law for whom the insured employee receives a dependency allowance from the Bank. Sponsored parents or parents-in-law can continue to be eligible when an employee retires, provided that (a) the retiree received a dependency allowance for that parent at the time of his/her retirement from the Bank and (b) that the parent was enrolled in the Insurable Benefits Program for at least one year prior to that time.

## When Coverage/Participation Begins

### Active Employees

If you are a Mandatory Participant in the IDB Insurable Benefits Program, your coverage as well as your dependent's coverage begins on your date of hire.

If you are an Optional Participant in the IDB Insurable Benefits Program, you may elect coverage during the first 30 calendar days from your date-of-hire or date of eligibility.

### Retirees

Retirees are eligible to participate in the Insurable Benefits Program on an optional basis. The decision to participate must be made when applying for a pension under the Staff Retirement Plan. This decision is irrevocable. For instance, **if you decide not to participate when you apply for your pension, you cannot apply to participate in the Medical Plan at a later date.**

### *Premium Vesting*

If you were hired by the Bank prior to September 1995 and you had at least 3 years of continuous coverage prior to your retirement, you are entitled to the subsidized premium rate.

## **Eligibility**

If you were hired on or after September 1995, you must have had at least 5 years of continuous coverage prior to your retirement date in order to receive the subsidized premium rate.

If you have less than 5 years of continuous coverage at the time you apply for retiree medical coverage, you may enroll in the IDB Medical Plan, paying both the retiree premium and the Bank premium. You will receive the subsidized premium rate when you have completed 5 years of continuous coverage.

### *Enrollment in Medicare*

If you elect to continue your participation in the IDB Medical Plan and you are eligible for Medicare Part B, you are required to enroll in the U.S. Medicare program upon reaching age 65.

For more information regarding your mandatory participation in the U.S. Medicare system, please contact the IDB Insurance Section.

### **When You and Your Spouse are Both Eligible for Coverage**

If you and your spouse are both eligible to participate in the IDB Insurable Benefits Program, there are special rules that apply. When both of you are active employees, or when one of you is an active employee and the other is a retiree, the one with the higher premium contribution rate will be designated as the member. The other will be designated as a dependent.

### **When Coverage/Participation Ends**

In general, coverage under the Insurable Benefits Program for active employees and any eligible dependent ends on the 30th day following the termination date of the active employee's services with the Bank.

### *Leave without Pay*

Employees absent on leave without pay for more than 30 calendar days will no longer have coverage for themselves or any eligible dependent after 30 days from the date the leave without pay began. During such 30-day period, the Bank will continue to pay its share of the premium for your coverage under the Program.

### *Coverage Termination for Spouses*

Spouses will not be covered under the Program 30 calendar days after a staff member's legal separation or divorce, as reflected in the staff member's marital status record with the Bank. During such 30-day period, the Bank will continue to pay its share of the premium for spouse coverage.

## **Eligibility**

### *Coverage Termination for Dependents*

Dependent children, parents, and parents-in-law will not be covered as dependents under the Program 30 calendar days after they no longer meet the Program's dependent eligibility requirements. During such 30-day period, the Bank will continue to pay its share of the premium for dependent coverage under the Program.

### **Extending Coverage after Termination**

Those active employees who end their employment with the Bank may continue participation in the Program for themselves and any eligible dependent for up to an additional 23 consecutive calendar months. In order to extend coverage, a terminating employee will need to pay his or her share of the premium cost *as well as* the Bank's share.

## Life Insurance Plans

This section provides details on the IDB life insurance plans. AIG is our life insurance carrier. Below you'll find information about the basic coverages that IDB offers as well as the supplemental coverages that you can buy.

### ***Life Insurance Plans for Active Staff***

#### **Eligibility**

You're eligible to participate in the IDB life insurance plans if you're a full-time employee working 20 or more hours per week.

#### **Basic Life Insurance**

This plan provides financial protection for your selected beneficiary in the event of your death.

##### *Coverage Amount*

The Basic Life plan provides benefits in an amount equal to 1½ times your net annual salary, rounded to the next highest thousand-dollar amount. For example, if your salary is \$49,500, your Basic Life coverage amount is \$75,000.

"Net annual salary" means your basic rate of pay, not including tax reimbursement, overtime, bonus or any other form of additional compensation.

The maximum coverage amount for Basic Life is \$500,000.

##### *When Coverage Begins*

Your Basic Life coverage begins on the day that you first become eligible to participate in the plan. For most employees, coverage begins on the date of hire.

##### *Coverage Reduction Schedule*

As long as you're employed by IDB and remain eligible to participate in the Basic Life plan, your coverage will stay at 1½ times your net annual salary until you reach age 70. At that time, your Basic Life coverage amount will be reduced by 50%, and will remain at that level for the rest of the time you're employed by IDB.

#### **Basic Dependent Life Insurance**

This plan provides a flat-dollar benefit to you in the event of the death of your spouse or covered dependent.

"Flat-dollar benefit" means a specific dollar amount that doesn't change and isn't related to your earnings.

## Life Insurance Plans

### *Coverage Amount*

If you're married, your spouse's coverage amount is \$10,000. For each of your eligible dependent children, the coverage amount is \$3,500.

To be eligible under the Basic Dependent Life plan, children must be at least 14 days old, and younger than 19 years of age. If your child is a full-time student and unmarried, eligibility is extended until the 25<sup>th</sup> birthday.

### *When Coverage Begins*

As with Basic Life, there's no waiting period for the Basic Dependent Life plan. Coverage begins on the day that you first become eligible to participate in the plan – your date of hire, or the day you meet other eligibility requirements.

### **Basic AD&D Insurance**

This plan pays benefits in the event of your death or serious injury due to an accident. "AD&D" is an abbreviation for Accidental Death and Dismemberment.

### *Coverage Amount*

If an accident causes your death, the Basic AD&D plan pays benefits in an amount equal to three times your net annual salary, rounded up to the next highest thousand-dollar amount.

For example, if your salary is \$49,500, your basic AD&D coverage amount is \$149,000. The maximum coverage amount for basic AD&D is \$1,000,000.

If an accident causes serious injury, the Basic AD&D benefit is a percentage of your coverage amount. This percentage varies according to the nature and extent of the injury.

The following table illustrates the Basic AD&D plan benefits for serious injuries:

If an injury causes the loss of:	The Basic AD&D plan provides the following %:
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and the sight of one eye	100%
One foot and the sight of one eye	100%
Speech and hearing in both ears	100%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Hearing in one ear	25%
Thumb and index finger of same hand	25%

## Life Insurance Plans

### *Limitation on Multiple Benefits*

If an accident causes multiple injuries, your total benefit will be limited to the percentage payable for the most serious loss. For example, if an accident caused the loss of sight in one eye as well as the loss of hearing in one ear, the benefit payable would be 50%.

Spouses while on official travel status (travel authorized and paid for by the Bank) are covered for \$20,000 in case of an accidental death.

### *Additional Benefits*

- Paralysis benefits — The Basic AD&D plan pays 100% of your coverage amount if an accident causes quadriplegia; 75% if an accident causes paraplegia; and 50% if an accident causes hemiplegia.
- Rehabilitation benefits — The Basic AD&D plan will pay up to \$5,000 for expenses associated with rehabilitation therapy after an accident that qualifies for AD&D benefits.
- Seat belt and air bag benefits — If you are injured or killed in a car accident, the Basic AD&D plan will pay additional benefits if you are wearing a seatbelt, or if your car's airbag inflates on impact at the time of the accident.

The additional seat belt benefit is the lesser of \$25,000 or 10% of your normal Basic AD&D benefit amount.

The additional air bag benefit is the lesser of \$10,000 or 10% of your normal Basic AD&D benefit amount.

### *When Coverage Begins*

There's no waiting period for the Basic AD&D plan. Coverage begins on the day that you first become eligible to participate in the plan – on your date of hire, or on the day you meet other eligibility requirements.

### *Coverage Reduction Schedule*

As long as you're employed by IDB and remain eligible to participate in the Basic AD&D plan, your coverage will stay at 100% of its face value until you reach age 65. At that time, coverage value begins to reduce, as the following table illustrates:

If you have an accident at:	Your benefit will be based on the following percentage of your pre-65 Basic AD&D coverage amount:
Age 65 through Age 74	65%
Age 75 or older	50%

## Life Insurance Plans



### *When Coverage Ends. . .*

Your Life Insurance coverage under the IDB group life insurance policies ends:

- 30 days following the day you terminate employment with IDB, or
- when you're no longer eligible to participate in the plan (for example, if you no longer work at least 20 hours per week)

Many of the plans have "conversion" and "portability" features, allowing you to continue coverage on your own after your employment with IDB. You'll find more details later in this section.

### *Your Cost for the Basic Coverages*

IDB pays 2/3rds of the cost for your basic coverage. You pay only a small portion of the combined cost of the basic life, basic dependent life, basic AD&D, and long-term disability plans.

### *Occupational Benefits*

If you die and your death is considered occupational (work-related), your death benefit amount is six times your net annual salary, rounded up to a maximum benefit of \$1,000,000.

If an occupational accident causes you serious injury, the percentages listed in the reference table still apply, but they'll apply to the higher occupational coverage amount of six times your net annual salary.

## **Supplemental Coverages You May Purchase**

In addition to the coverage that IDB provides, you can also choose supplemental coverage for yourself and your spouse. You decide on the coverage amount you want and then pay the full cost, which is based on your age (or your spouse's age, when applicable).

Below is a description of how each of the supplemental coverage options works.

### **Supplemental Life Insurance for You**

This plan provides additional cash benefits in the event of your death.

#### *Coverage Amount*

You may choose coverage in \$20,000 increments. Your coverage limit is the lesser of:

## Life Insurance Plans

- 7½ times your basic annual earnings, or
- Taking into account your Basic Life and Supplemental Life coverages *combined*, an amount not to exceed \$1,000,000.

### *Cost*

You pay the cost for this coverage. Your age at the time you elect coverage determines your premium rate. Rates increase as age increases. At the end of this section, you'll find a table showing the current supplemental life premium rates for you.

### *When Coverage Begins*

You must elect coverage within the first 30 days after you're first eligible or you'll need to submit proof of good health if you want coverage at a later time.

### *Coverage Reduction Schedule*

Your Supplemental Life coverage amounts remain at 100% of the level you've chosen, until you reach age 65. At that time, coverage value begins to reduce, as the following table illustrates:

If your death occurs at:	Your benefit will be based on the following percentage of your pre-65 Supplemental Life coverage amount:
Age 65	65%
Age 70 or older	50%

## **Supplemental Life Insurance for your Spouse**

This plan provides additional cash benefits in the event of your spouse's death.

### *Coverage Amount*

You may choose coverage in \$10,000 increments. The coverage limit for this plan is the lesser of:

- \$200,000, or
- 50% of YOUR Basic Life and Supplemental Life coverages combined

### *Cost*

You pay the cost for this coverage. Your spouse's age at the time he/she elects coverage determines his/her premium rate. Rates increase as age increases. At the end of this section, you'll find a table showing the current supplemental life rates that apply for your spouse.

## Life Insurance Plans

### *When Coverage Begins*

There's no waiting period for Supplemental Life coverage for your spouse. However, if you don't elect coverage for your spouse within the first 30 days after you're first eligible to participate in the plan, you may be required to submit proof of your spouse's good health if you want coverage at a later time.

### *Coverage Reduction Schedule*

The same coverage reduction provisions that apply to Supplemental Life coverage for you also apply to coverage for your spouse.

### **Guarantee Issue Amounts**

"Guarantee Issue" is the amount of insurance AIG will provide without requiring proof of good health as long as you apply for coverage within 30 days after first becoming eligible. The Supplemental Life plans include the following guarantee issue amounts:

- For you, the lesser of \$800,000 or 5 times your basic annual earnings, taking into account the *combination* of your Basic Life coverage and the additional Supplemental Life coverage you want for yourself
- For your spouse, \$50,000

Depending on your salary, you may be eligible to purchase coverage in an amount that exceeds the guarantee issue amounts. In that case, you (or your spouse, if applicable) will need to submit proof of good health to AIG.

Proof of good health consists of a brief questionnaire about your (or your spouse's) health status. After reviewing your questionnaire responses, AIG will make a decision to approve your requested coverage amount or ask for more information before making a determination.

Remember that you can always apply for additional coverage up to the plan's maximum coverage limits, but the portion of the coverage above the guarantee issue limit will require proof of good health.

### **Supplemental AD&D Coverage for You, Your Spouse and Your Children**

This plan provides additional cash benefits in the event of your death or serious injury due to an accident.

### *Coverage Amount*

You may select any amount of coverage in \$20,000 increments, up to the lesser of:

## Life Insurance Plans

- \$500,000, or
- 10 times your basic annual earnings

The coverage total you select is called the “principal amount.” It’s the amount of coverage that applies to you only.

You may choose to cover yourself only, or to cover yourself and your eligible family members. If you decide to cover your spouse and/or your dependent children, coverage levels for them are based on a percentage of your principal amount.

Here’s the schedule of coverage amounts if you select the family plan:

Your spouse only	60% of your principal amount
Your child only	20% of your principal amount
Your spouse and child	50% of your principal amount for your spouse, <i>and</i> 15% of your principal amount for your child

If you (or one of your eligible dependents) die or are seriously injured due to an accident, the Supplemental AD&D plan pays the following benefits:

If an injury causes the loss of:	The Supplemental AD&D plan provides the following % of your principal amount:
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and the sight of one eye	100%
One foot and the sight of one eye	100%
Speech and hearing in both ears	100%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing in both ears	50%
Hearing in one ear	25%
Thumb and index finger of same hand	25%

### *Limitation on Multiple Benefits*

If an accident results in multiple losses, benefits are payable for each loss, up to a total benefit equal to 100% of your principal amount.

### *Additional Benefits*

The Supplemental AD&D plan includes additional provisions that enhance benefits under certain circumstances:

## Life Insurance Plans

- **Common disaster benefit** – If you're enrolled for family coverage and you and your spouse both die due to the same accident, the Supplemental AD&D benefit for your spouse is the lesser of \$500,000 or 100% of your principal amount.
- **Paralysis benefits** — The Supplemental AD&D plan pays 100% of the coverage amount if an accident causes quadriplegia; 75% if an accident causes paraplegia; and 50% if an accident causes hemiplegia.
- **Rehabilitation benefits** — The Supplemental AD&D plan will pay up to \$5,000 for expenses associated with rehabilitation therapy after an accident that qualifies for AD&D benefits.
- **Seat belt and air bag benefits** — In the event of injury or death due to a car accident, the Supplemental AD&D plan will pay additional benefits for wearing a seatbelt, or if the car's airbag inflates on impact at the time of the accident.

The additional seat belt benefit is the lesser of \$25,000 or 10% of the normal Supplemental AD&D benefit amount.

The additional air bag benefit is the lesser of \$10,000 or 10% of the normal Supplemental AD&D benefit amount.

- **Day care benefit** — If you're enrolled for family coverage and you die because of an accident, the plan pays benefits for daycare expenses on behalf of your eligible child(ren) under age 13. The benefit is payable each year for up to four years following your death or four years after your eligible child is first enrolled in a day care center.

The maximum day care benefit each year is equal to the lesser of (a) the actual cost of the care, (b) 2% of your principal amount, or (c) \$2,000.

- **Tuition benefit** — If you're enrolled for family coverage and you die because of an accident, the plan pays benefits for certain tuition expenses for your eligible children and for your spouse.

For your insured dependent children under age 23 — Your child is eligible for a tuition benefit under the Supplemental AD&D plan if he or she is:

- A full-time college student, or
- A high school senior who enrolls at college within a year of your death

The benefit is payable each year, to a maximum of four consecutive years. The maximum tuition benefit each year is equal to the lesser of (a) the actual cost of the tuition, not counting room and board (b) 5% your principal amount, or (c) \$5,000.

## Life Insurance Plans

If your child loses his or her full-time student status at any point while receiving the tuition benefit, no additional benefits are payable, even if the child regains full-time student status at a later date.

If you're enrolled for family coverage and none of your insured children is old enough to qualify for the tuition benefit within one year of your death, the Supplemental AD&D plan will pay a one-time \$5,000 benefit to your designated beneficiary.

### *Cost*

You pay the cost for this coverage. Your premium rate depends on the amount of coverage you purchase and whether you're electing coverage for just yourself or for your family. At the end of this section, you'll find a table showing the current supplemental AD&D premium rates.

### *When Coverage Begins*

There's no waiting period for the Supplemental AD&D program.

### *Coverage Reduction Schedule*

Your Supplemental AD&D coverage amounts remain at 100% of the level you've chosen, until you reach age 70. At that time, coverage value begins to reduce, as the following table illustrates:

If you have an accident at:	Your benefit will be based on the following percentage of your pre-70 Supplemental AD&D coverage amount:
Age 70	65%
Age 75 through Age 79	45%
Age 80 through Age 84	30%
Age 85 and older	15%

## Other Details to Know about the Active Staff Life Insurance Plans

### *Designating Your Beneficiaries*

Your "beneficiaries" are the people who receive benefits in the event of your death. When you enroll for coverage in the life insurance plans – both the plans that IDB provides and the supplemental coverages you may decide to purchase – you'll need to complete beneficiary designation cards.

## Life Insurance Plans

Your beneficiaries can be anyone you decide. You can name a different beneficiary for each plan, and you can change your beneficiaries at any time. When you enroll in the plans, you'll receive beneficiary cards to complete and return to the IDB Insurance Section.

If you cover dependents under any of the basic and supplemental plans, you are automatically your dependents' beneficiary.

It's important to designate the beneficiaries you wish to receive the benefits from your Life Insurance coverages. If you die without designating beneficiaries, benefits will be paid to your closest survivors:

- First, to your spouse; if there's no spouse, then
- Second, to your children; if there are no children, then
- Third, to your parents; if there are no parents, then
- Fourth, to your brothers and sisters; if there are no brothers and sisters, then
- To your estate.

### *Waiver of Premium*

If you are under the age of 60 and should become totally disabled while you're covered under the life insurance plans, you may be eligible for "waiver of premium."

"Totally disabled" means that you are unable to engage in any employment or occupation you would be qualified for based on your education, training, skill, or experience.

If a disability qualifies you for waiver of premium, you'll continue to be covered at the same pre-disability benefit levels, but you won't have to pay premiums for the duration of your total disability, or until normal retirement age – whichever comes first.

To apply for waiver of premium, you'll need to supply documentation of your total disability.

### *Conversion*

If you leave IDB, or if you become ineligible to participate in the Life Insurance plans, you can choose to "convert" your basic coverage to an individual policy. When you leave IDB or become ineligible, you'll have 31 days to decide about conversion.

If you decide to convert any of your coverage, you should contact AIG. AIG will give you all the details about your individual policy and the premium you need to pay. Keep in mind that the premium you pay for individual coverage will be different than the premium under the IDB group policies.

## Life Insurance Plans

### *Portability*

If you leave IDB, your supplemental life coverage is “portable” – meaning that you can keep the same level of coverage you had while you were at IDB and won’t need to submit any additional proof of good health. After you leave IDB, you make premium payments directly to the insurance carrier.

### *Accelerated Benefits*

If you or one of your covered family members is diagnosed with a terminal illness, you may be eligible for “accelerated benefits.” This means that you can receive a portion of your life insurance benefit when you may need it most.

If you’re approved for accelerated benefits, you’ll receive the lesser of:

- 50% of your Basic and Supplemental Life coverage benefit, or
- \$100,000

### *Filing Claims*

The Insurance Section will coordinate the filing of claims with the family and/or beneficiaries with AIG. In all cases a certified copy of the death certificate will be required.

### *Payment*

For most claims, AIG will pay benefits in a “lump sum.” That means that the benefit will be a one-time payment for the entire coverage amount.

## ***Death Benefit Plans for Retirees***

### **Eligibility**

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

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

## Life Insurance Plans

### Coverage Amount

There are two coverage options: low and high:

#### *Low Option Coverage:*

Flat-dollar benefits for you and your spouse. You're automatically covered for the low option, unless you're eligible for and elect high option coverage instead. The low option provides the following benefits:

- Coverage for you – \$10,000
- Coverage for your spouse – \$5,000

#### *High Option Coverage:*

- Coverage for you – A percentage of your final base salary, rounded to the next \$1,000.

“Final base salary” means the annual amount of your regular compensation just prior to your retirement. It does not include tax reimbursements, bonuses, overtime, special pay or separation payments, temporary salary increases, or lump-sum payments made in lieu of annual leave.

The percentage of your final base pay that will be payable as a benefit under the plan depends on your age at the time of death, as the following table illustrates:

If death occurs at age:	Your benefit amount, as a percentage of your final base salary will be:
50 through 61	150%
62	100%
63	94%
64	88%
65	82%
66	76%
67	70%
68	64%
69	58%
70	52%
71	46%
72 and over	10%, but not less than \$15,000

## Life Insurance Plans

For example, if your final base pay at retirement was \$99,000, and your death occurred at age 65, the table indicates that 82% of your final base pay rounded to the next \$1,000 amount (in this example, \$82,000) would be payable as a benefit under the retiree plan.

- Coverage for your spouse – \$7,500.

### Electing Coverage

*Low Option* – If you want the coverage provided under the low option, you don't need to make an election because you're automatically covered as long as you meet the eligibility requirements of the plan.

*High Option* – If you want the coverage the high option provides, you'll need to make a written election. You must make this written election before your IDB pension becomes effective.

If you select high option coverage for yourself, you may (but are not required to) select high option coverage for your spouse.

If you select high option coverage, it is a replacement for (rather than an addition to) the low option coverage.

### Coverage Cost

*Low Option* – If you want just the coverage provided under the low option, IDB pays the premium cost.

*High Option* – If you want the coverage the high option provides, you pay a monthly premium amount based on current retiree life premium rates. At the end of this section, you'll find a table showing the current retiree life premium rates that apply for you and your spouse.

### Other Details to Know about the Death Benefit for Retirees

#### *Designating Your Beneficiaries*

Your beneficiaries can be anyone you decide. It's important to designate the beneficiaries you wish to receive your retiree life benefits. If you die without designating beneficiaries, benefits will be paid to your closest survivors:

- First, to your spouse; if there's no spouse, then
- Second, to your children; if there are no children, then

## Life Insurance Plans

- Third, to your grandchildren; if there are no grandchildren, then
- Fourth, to your parents; if there are no parents, then
- Fifth, to your brothers and sisters; if there are no brothers and sisters, then
- To your estate.

### *Filing Claims*

Notice of death should be provided directly to the Insurance Section. In order to pay benefits to the named beneficiary, the Insurance Section must receive proof of death in the form of a certified copy of the death certificate.

### *Payment*

Your beneficiar(ies) will receive benefits in a “lump sum,” a one-time payment for the entire coverage amount.

## Life Insurance Plans

### Life Insurance Premium Rates – Active Staff & Retirees

On this page, you'll find the premium rates that you will pay when you elect supplemental life coverage or, if applicable, high option retiree life coverage. These are the current rates, but remember that they're subject to change.

Coverage	Monthly Premium Rates
<i>Supplemental Life for You or Your Spouse</i>	(age-banded rates)
-- to age 24	\$0.20 per \$1,000 of coverage selected
-- age 25-29	\$0.20 per \$1,000 of coverage selected
-- age 30-34	\$0.21 per \$1,000 of coverage selected
-- age 35-39	\$0.22 per \$1,000 of coverage selected
-- age 40-44	\$0.24 per \$1,000 of coverage selected
-- age 45-49	\$0.26 per \$1,000 of coverage selected
-- age 50-54	\$0.38 per \$1,000 of coverage selected
-- age 55-59	\$0.50 per \$1,000 of coverage selected
-- age 60-64	\$0.68 per \$1,000 of coverage selected
-- age 65-69	\$1.42 per \$1,000 of coverage selected
-- age 70 and up	\$2.34 per \$1,000 of coverage selected
<i>Supplemental AD&amp;D</i>	
-- for you only	\$0.02 per \$1,000 of coverage selected
-- for you and your family	\$0.03 per \$1,000 of coverage selected
<i>Retiree Death Benefit</i>	
-- Low Option	No premium cost
-- High Option for Retiree	\$0.50 per \$1,000 of covered benefit
-- High Option for Retiree's spouse	\$2.90 per month

## Long-Term Disability

This section includes information about the IDB Long-term Disability (“LTD”) plan. The LTD plan provides income protection in the event that an injury or illness prevents you from working for an extended period.

### Eligibility

You’re eligible to participate in the IDB LTD plan if you’re a full-time employee working 20 or more hours per week.

### How the LTD Plan Works

If a total disability causes you to be eligible for LTD benefits, the LTD Plan will provide a monthly benefit equal to 72% of your **basic monthly salary** in effect on your last day as an active full-time employee before becoming disabled. The maximum monthly LTD benefit payment is \$10,000.

“Total Disability” can be due to an accidental injury, sickness, mental illness, substance abuse, or pregnancy. It means that, as a result of one of the conditions, you’re unable to perform any of the duties of your job at IDB during the first 24 months of your disability. If you remain disabled after 24 months, you will be considered totally disabled if you are unable to engage in any employment or occupation you would be qualified for, based on your education, training, skill, or experience.

“Basic monthly salary” means your regular monthly pay, not including income tax reimbursement, commissions, bonuses, overtime pay, any other fringe benefit or extra compensation.

### When Payments Begin

The LTD Plan provides benefits when a disability prevents you from working for six months or longer. To be eligible for LTD benefits, your disability must continue for six consecutive months. These six months are sometimes referred to as the “elimination period.”

LTD benefits begin on the first day after the six-month elimination period.

### Duration of LTD Benefits

To determine how long your LTD benefits should be paid, our insurer considers how a disability affects your ability to do your work.

For the first two years, you’ll continue to receive LTD benefit payments if your disability prevents you from performing a majority of the duties of *your* job.

## Long-Term Disability

After two years, you'll continue to receive LTD benefits if your disability prevents you from performing the duties of *any* job that you would be qualified to do, based on your education, training and experience.

As long as you continue to be eligible for LTD benefits, your payments will continue until your normal retirement date, or the date you reach age 62 – whichever date is earlier.

### How LTD Benefits Coordinate with Pension Benefits

If you receive a disability pension from the IDB pension plan, your pension benefits will coordinate with the benefits that the LTD Plan provides. This means that the combined disability benefit from the IDB pension plan along with the LTD Plan benefits will not exceed 72% of your last net annual salary.

### When Benefits End

Generally, LTD Plan benefits end on the day you're no longer disabled, or upon death. But there are other reasons that your benefits might stop. It's important to provide our insurance carrier all the periodic information they will need to certify your continued disability.

Your benefits could end suddenly if you:

- Fail to furnish proof that you continue to be disabled
- Refuse to be examined by a physician
- Refuse to receive recommended treatment that your doctor or our insurer believes will cure, ease, or limit your disability

### What's Not Covered

The LTD Plan will not pay benefits for a disability that:

- Is caused or contributed to by war or an act of war
- Is caused by service in the armed forces of your country
- Is caused by your commission of a felony or other illegal activity
- Is caused by a self-inflicted injury



To receive any LTD Plan benefits, you must be under the regular care of a physician.

## Long-Term Disability

### Pre-Existing Conditions

Pre-existing limitations apply to the LTD plan. As a reminder, a pre-existing condition is any diagnosed illness, injury, or other condition that you received treatment for before you were covered by the IDB Insurable Benefits Program.

To be eligible for LTD Plan benefits for a pre-existing condition, your disability must begin after one year during which you're continuously insured for benefits relating to the pre-existing condition.

### Recurring Disabilities

Recovering from a disability and returning to work for a period time, then becoming disabled again is called a "recurring disability." When this happens, our insurer uses certain guidelines to determine whether your most recent condition is related to the earlier disability or whether it should be classified as a new disability.

A recurring disability will be classified as a continuation of an earlier disability if:

- It is due to the same or related cause, and
- It occurs within six months of when you first tried to return to work after first becoming disabled

A recurring disability will be classified as a new disability if:

- You return to work for six months or more before becoming disabled again.

In this case, you would need to satisfy a new 6-month elimination period before the LTD Plan paid additional benefits.

### Subrogation

If you suffer a disability because of the actions or neglect of another person or organization, a third party (for example, an insurance company) might be liable or legally responsible to provide disability benefits on your behalf. In the handbook section titled, "General Limitations and Exclusions," you'll find more information about subrogation.

### Claim Filing

The Insurance Section will coordinate the application process with you.

## The Medical Plan



The Medical Plan provides comprehensive medical benefits for you and your covered family members. CIGNA is the administrator of the Medical Plan. This section will provide an overview of the Medical Plan, how it's organized and what you need to do to make sure you get the maximum benefit from the program.

### Medical Plan Overview

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

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

The plan is called a Preferred Provider Organization, or "PPO," plan. It provides both in-network and out-of-network benefits. Each time you need medical care, you choose what level of benefits you want to receive. Your benefits are greater when you use PPO network providers.



The PPO network is a group of hospitals, doctors, and other health care professionals that provide medical care at discounted rates for CIGNA Medical Plan members. That means that generally, your costs are lower when you use PPO network providers. The IDB intranet site includes a link to CIGNA network information. Log on to find out if your doctors are in the CIGNA PPO network. Or you may call CIGNA Member Services and a CIGNA representative can look up the information for you.

If you decide to use out-of-network providers, you're still covered under the Medical Plan, but you'll need to pay a deductible and a higher percentage of the cost. Generally, you pay more for out-of-network services.

### Care Outside the U.S.

If you're based in a Country Office, on mission, on vacation, or retired and living abroad, your care outside the U.S. is considered in-network. That means that you won't need to pay a deductible and that the Plan will pay benefits at the higher, in-network level.

## The Medical Plan

### Finding PPO Providers

#### *Using the IDB Intranet and the Internet*

The IDB intranet includes a “link” to CIGNA’s PPO provider directory. There, you’ll find information on network hospitals, doctors, and other health care providers in your area. CIGNA updates its online directory often so it’s usually the best resource for finding the most recent provider list.

#### *Using the Internet*

You can go directly to CIGNA’s online PPO provider directory at MYCIGNA.COM.

### Medical Plan Terms to Know

To understand how the plan works, you should be familiar with these terms that you’ll see frequently in connection with your benefits:

- **Deductible:** A “deductible” is an annual amount you must pay for out-of-network services before the Medical Plan pays benefits for eligible expenses. If you’re covering only yourself under the plan, your annual deductible is \$200. If you’re covering yourself and your family members, the annual deductible for you and your family combined is \$400. There’s no deductible when you use PPO network providers.
- **Coinsurance:** The portion that the plan pays (or that you pay) is called “coinsurance.” On the following pages, you’ll find a table that lists the Medical Plan’s coinsurance amounts for covered services. After the plan pays, the balance of the cost is the coinsurance that you pay.
- **Service-Specific Maximum:** Specific dollar maximums apply for certain benefits. In the table of covered medical services on the following pages, you’ll see each of the benefits that have a service-specific maximum.
- **Out-of-Pocket Maximum:** The Medical Plan includes a limit on the amount you spend each year for benefits. This is your “out-of-pocket maximum.” If you cover just yourself under the Medical Plan, there’s an individual maximum that applies to you only. If you cover your family too, there’s a maximum that applies for 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.

## The Medical Plan

- *Reasonable and Customary*: This term applies to your eligible medical expenses for out-of-network services. The Medical Plan pays out-of-network benefits according to “reasonable and customary” or “R&C” guidelines. R&C means the average, prevailing cost in a particular geographic area. If your out-of-network provider’s charge is higher than R&C for your area, the Medical Plan pays its usual percentage of only the R&C amount. Any charges exceeding the R&C amount will be your responsibility.

CIGNA relies on regularly updated R&C guidelines provided by the Health Insurance Association of America.

Remember that R&C only applies to out-of-network services. If you use in-network services, charges are based on pre-negotiated rates with PPO providers.

On the following pages, you’ll find the Table of Covered Medical Services. It outlines most of the benefits that the Medical Plan provides, and includes:

- Deductibles that you pay for certain services
- Coinsurance that the plan pays
- Service-specific maximums for certain benefits
- Out-of-pocket maximums that apply to the coverage level you select, and
- Out-of-network benefits that the Medical Plan pays based on R&C guidelines.

The table lists most of the services that the plan covers. However, if you have a question about other benefits, call CIGNA Member Services or the IDB Insurance Section for more information.

### *What the underlined terms in the table mean*

Services in the chart that are underlined indicate that, in the United States, those services are subject to pre-admission certification and/or continued stay review. Later in this section, you’ll find more details on those programs and when they apply to your Medical Plan benefits.

Just after the table, you’ll find more information on special provisions that apply for certain benefits, along with more details on what the Medical Plan covers and the services it does not pay for.

## The Medical Plan

### Table of Covered Medical Services

	In Network	Out-of-Network
	Unlimited	Unlimited
<b>Lifetime Maximum</b>		
<b>Deductible (per calendar year)</b> <ul style="list-style-type: none"> <li>■ Individual</li> <li>■ Family maximum</li> </ul>	<ul style="list-style-type: none"> <li>■ None</li> <li>■ None</li> </ul>	<ul style="list-style-type: none"> <li>■ \$200</li> <li>■ \$400</li> </ul>
<b>Out-of-Pocket Maximums (per calendar year)</b> <ul style="list-style-type: none"> <li>■ Includes deductibles</li> <li>■ Individual maximum</li> <li>■ Family maximum</li> <li>■ Includes penalties for non-compliance with pre-certification</li> <li>■ Includes charges paid in excess of reasonable and customary ("R&amp;C")</li> </ul>	<ul style="list-style-type: none"> <li>■ Not applicable</li> <li>■ \$1,000</li> <li>■ \$2,000</li> <li>■ No</li> <li>■ Not applicable</li> </ul>	<ul style="list-style-type: none"> <li>■ Yes</li> <li>■ \$2,000</li> <li>■ \$4,000</li> <li>■ No</li> <li>■ No</li> </ul>
	<b>The Plan Will Pay:</b>	<b>The Plan Will Pay:</b>
<b>Doctor's Office Visits</b> <ul style="list-style-type: none"> <li>■ For Illness</li> <li>■ For Injury</li> </ul>	<ul style="list-style-type: none"> <li>■ 90%</li> <li>■ See Emergency Care</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% of R&amp;C, after deductible</li> <li>■ See Emergency Care</li> </ul>
<b>Routine Preventive Care</b> <ul style="list-style-type: none"> <li>■ For children through age 2</li> <li>■ For children over age 2 and adults</li> </ul>	<ul style="list-style-type: none"> <li>■ 100%</li> <li>■ 100% (annual maximum of \$500)</li> </ul>	<ul style="list-style-type: none"> <li>■ 100% of R&amp;C</li> <li>■ 100% of R&amp;C (annual maximum of \$500)</li> </ul>
<b>Second Opinion for Surgery</b> (includes Lab & X-ray)	■ 100%	■ 100% of R&C
<b>Pre-admission Testing</b>	■ 100%	■ 80% of R&C, after deductible
<b>Inpatient Hospital Facility Services</b> <ul style="list-style-type: none"> <li>■ Semi-private (SP) room</li> <li>■ Private room</li> <li>■ Intensive Care Unit (ICU)</li> <li>■ Doctor's Visits/Consultations</li> <li>■ Professional Services</li> </ul>	<ul style="list-style-type: none"> <li>■ 100% (of negotiated rate)</li> <li>■ 100% (of SP negotiated rate)</li> <li>■ 100% (of negotiated rate)</li> <li>■ 90%</li> <li>■ 100%</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible (up to SP rate limit)</li> <li>■ 80% of R&amp;C, after deductible (up to ICU daily rate limit)</li> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> </ul>
<b>Outpatient Surgery</b> <ul style="list-style-type: none"> <li>■ Facility services</li> <li>■ Professional services</li> </ul>	<ul style="list-style-type: none"> <li>■ 100%</li> <li>■ 100%</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> </ul>
<b>Emergency Care</b> <ul style="list-style-type: none"> <li>■ Includes ambulance services when medically necessary</li> </ul>	■ 100%	■ 100% of R&C

## The Medical Plan

	In Network	Out-of-Network
	The Plan Will Pay:	The Plan Will Pay:
<b>Lab &amp; X-Ray Services</b>		
■ Outpatient at a hospital	■ 100%	■ 80% of R&C, after deductible
■ At a lab and x-ray facility	■ 90%	■ 80% of R&C, after deductible
■ At a doctor's office	■ 90%	■ 80% of R&C, after deductible
<b>Outpatient Short-Term Rehabilitation</b>	■ 90%	■ 80% of R&C, after deductible
<b>Kidney Dialysis</b>	■ 90%	■ 80% of R&C, after deductible
<b>Home Health Care</b>		
■ Up to 40 visits per calendar year	■ 90%	■ 80% of R&C, after deductible
<b>Outpatient Private Duty Nursing</b>	■ 90%	■ 80% of R&C, after deductible
<b>Hospice</b>		
■ Semi-private or private room	■ 100%, (based on negotiated rate)	■ 80% of R&C, after deductible (up to SP rate limit)
<b>Organ Transplants</b> (Includes all medically appropriate non-experimental transplants)		
■ Inpatient facility	■ 100%	■ 80% of R&C, after deductible
■ Semi-private (SP) room	■ Limited to SP negotiated rate	■ 80% of R&C, after deductible (up to SP rate limit)
■ Private room	■ Limited to SP negotiated rate	■ 80% of R&C, after deductible (up to SP rate limit)
■ Intensive care unit (ICU)	■ Limited to negotiated rate	■ 80% of R&C, after deductible (up to ICU daily rate limit)
■ Physician (surgical) services	■ 100%	■ 80% of R&C, after deductible
■ Inpatient visits/consultations	■ 90%	■ 80% of R&C, after deductible
<b>Durable Medical Equipment</b>	■ 90%	■ 80% of R&C, after deductible
<b>External Prosthetic Appliances</b>	■ 90%	■ 80% of R&C, after deductible
<b>Mental Health &amp; Substance Abuse</b>		
■ <u>Inpatient</u>	■ 100% (up to 45 days per stay)*	■ 80% of R&C, after deductible (up to 45 days per stay)*
■ Physician charges	■ 80%	■ 80% of R&C, after deductible
■ Outpatient	■ 80% (\$4,800 maximum per calendar year, combined with out-of-network charges)	■ 80% of R&C, after deductible (\$4,800 maximum per calendar year, combined with in-network charges)

\* If, upon review for medical necessity, INTRACORP determines that additional inpatient days are necessary, the Medical Plan will cover those expenses.

## The Medical Plan

	In-Network	Out-Of-Network
	The Plan Will Pay:	The Plan Will Pay:
<b>Maternity</b> <ul style="list-style-type: none"> <li>■ Initial visit to determine pregnancy</li> <li>■ <u>Delivery</u> (includes all subsequent prenatal and postnatal visits)</li> <li>■ <u>Hospital</u> (includes birthing centers)</li> </ul>	<ul style="list-style-type: none"> <li>■ 90%</li> <li>■ 100%</li> <li>■ 100%</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> </ul>
<b>Abortion</b> (Includes elective or non-elective procedures for any eligible family member) <ul style="list-style-type: none"> <li>■ Office visits</li> <li>■ <u>Inpatient facility</u></li> <li>■ <u>Outpatient facility</u></li> <li>■ Physician's (surgical) services</li> </ul>	<ul style="list-style-type: none"> <li>■ 90%</li> <li>■ 100%</li> <li>■ 100%</li> <li>■ 100%</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> </ul>
<b>Family Planning</b> <ul style="list-style-type: none"> <li>■ Office visits (including tests and counseling)</li> <li>■ Surgical sterilization procedures (for vasectomy/tubal ligation, including reversals of the same)</li> </ul>	<ul style="list-style-type: none"> <li>■ 90%</li> <li>■ 100%</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> </ul>
<b>Infertility Treatment</b> <ul style="list-style-type: none"> <li>■ Office visits (including tests and counseling)</li> <li>■ Surgical procedures for infertility (including AI, IVF, GIFT, ZIFT, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>■ 90%</li> <li>■ 100%</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% of R&amp;C, after deductible</li> <li>■ 80% of R&amp;C, after deductible</li> </ul>
<b>Hearing Aid Benefit</b> <ul style="list-style-type: none"> <li>■ Hearing evaluation or test, and any hearing aid(s) prescribed, including their repair.</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% Up to a maximum of \$5,000 every five years</li> </ul>	<ul style="list-style-type: none"> <li>■ 80% Up to a maximum of \$5,000 every five years</li> </ul>
<b>Screening Mammography</b>	<ul style="list-style-type: none"> <li>■ 100%</li> </ul>	<ul style="list-style-type: none"> <li>■ 100% of R&amp;C</li> </ul>

## The Medical Plan

### Covered Medical Services

- *Routine Care Benefits.* You and your covered dependents are eligible for routine care benefits (for example, immunizations, annual physicals, etc.) at all times (up to the annual benefit maximums). As a Bank employee, you're not eligible for routine care benefits during the calendar year in which you must comply with the Bank's Periodic Medical Examination. Please see Staff Rule 374 for details.
- *Ambulances.* Charges for local ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided. Local ambulance service includes Medivac helicopters, as long as their use is medically warranted.
- *Hospital bed, hospital board, services, and supplies.* Charges made by a hospital for bed and board, and for other necessary services and supplies (subject to the limits shown in the schedule).
- *Outpatient hospital medical care.* Charges made by a hospital, for medical care and treatment provided on an outpatient basis.
- *Surgical facility charges.* Charges made by a freestanding surgical facility, for medical care and treatment.
- *Outpatient mental health services.* Charges made by a facility licensed to furnish mental health services, for care and treatment of mental illness provided on an outpatient basis.
- *Outpatient treatment of alcohol and drug abuse.* Charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.
- *Physician and other fees.* Charges made by a physician, a psychologist and other licensed health care professional services.
- *Professional nursing services.* Charges made by a nurse for professional nursing services.
- *Anesthetics.* Charges made for anesthetics and their administration.
- *Lab tests.* Charges for diagnostic X-ray and laboratory examinations.
- *Radiation and other treatments.* Charges for radium and radioactive isotope treatment, and chemotherapy.
- *Blood.* Charges for blood transfusions, and blood not donated or replaced.
- *Gases.* Charges for oxygen and other gases and their administration.
- *Hearing Aids:* Charges for hearing aids or examinations for prescription or fitting thereof.

## The Medical Plan

- *Equipment.* Durable medical equipment may be purchased if it provides cost-effective alternative to rental. CIGNA must approve all durable medical equipment purchases.
  - *Prosthetic devices.*
  - *Dressings and prescriptions.* Charges for dressings, and drugs and medicines lawfully dispensed only upon the written prescription of a physician.
  - *Physical, occupational, or speech therapy.* Charges for therapy provided by a licensed physical, occupational or speech therapist.
  - *Organ transplants.* Charges made for or in connection with approved organ transplant services, including immuno-suppressive medication; organ procurement cost and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other plan.
  - *Cataract surgery follow-up.* Charges made for the purchase of the first pair of eyeglasses or contact lenses following cataract surgery.
  - *Home Health Care* <sup>\*</sup>. Charges made by a home health care agency for the following medical services and supplies provided under the terms of a home health care plan for the person named in that plan:
    - part-time or intermittent nursing care by or under the supervision of a registered graduate nurse
    - part-time or intermittent services of a home health aide
    - physical, occupational, respiratory or speech therapy
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a physician; and laboratory services; but only to the extent that such charges would have been considered covered expenses had a person required confinement in the hospital as a registered bed patient or confinement in a skilled nursing facility.
- <sup>\*</sup> INTRACORP case management must approve home health care benefits
- *Hospice care.* Charges made due to terminal illness for the following hospice care services provided under a hospice care program:
    - by a certified hospice facility for bed and board and services and supplies, subject to the limitations shown in the schedule
    - by a hospice facility for services provided on an out-patient basis

## The Medical Plan

- by a physician for professional services
- for pain relief treatment, including drugs, medicines and medical supplies.

### Non-Covered Services

Following is a list of non-covered services. If you have questions about whether the Medical Plan covers a particular service, contact CIGNA Member Services or the IDB Insurance Section.

The Medical Plan **DOES NOT** pay benefits for:

- Ambulance travel by airplane
- Charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society or national authorities
- Penalties imposed by any certification requirement shown in the schedule
- Charges made by a physician for or in connection with multiple surgeries that exceed the following maximum: when two or more surgical procedures are performed through the same surgical incision, the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and one-half the amount otherwise payable for all other surgical procedures
- Charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts)
- Speech therapy (a) used to improve speech skills that have not been fully developed; (b) that can be considered custodial or educational; or (c) is intended to maintain speech communication. Speech therapy that is not restorative in nature will not be covered
- Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder
- Transsexual surgery and related services
- Charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, such as the removal of calluses and corns or the trimming of nails, unless medically necessary
- Charges for or in connection with cosmetic surgery, unless (a) a person receives an injury, while insured for these benefits, which results in bodily damage requiring the surgery; or (b) it qualifies as reconstructive surgery performed on a person following surgery; and both the

## The Medical Plan

surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed on any one of your dependents who is less than 16 years old to correct a congenital anomaly

- Charges for a second surgical opinion rendered more than six months after a surgeon has first recommended the surgical procedure
- Charges made for or in connection with the routine eye refractions, eye exercises, and for the surgical treatment for correction of refractive errors, including radial keratotomy, when eyeglasses or contact lenses may be worn, except as provided for under the vision care plan in the schedule
- Home Health Care. The following expenses for services of a home health care agency are not included as covered expenses:
  - Home health care visits in excess of 40 during a calendar year (each visit by an employee of a home health agency will be considered one home health visit, and each four hours of home health aide services will be considered one home health care visit)
  - Care or treatment that is not stated in the home health care plan; or
  - Any period when a person is not under the care of a physician.
- Hospice Care. The following expenses for hospice care services are not included as covered expenses:
  - Any period when you or your dependent is not under the care of a physician
  - Services or supplies not listed in the hospice care program
  - Any curative or life-prolonging procedures
  - Services or supplies that are primarily to aid you or your dependent in daily living; or
  - To the extent that any other benefits are payable for those expenses under the policy.



For more information about exclusions that apply to the Medical Plan, see the section titled, "Coverage Limits and Exclusions."

## The Medical Plan

### Pre-Admission Certification (U.S. hospital confinements only)

#### *What You Need to Know and Do*

When you need to schedule a hospital stay, it's important to certify your inpatient care *before* you're admitted. (If you're hospitalized because of an emergency, certifying your care takes place after you're admitted.)



Anyone aware of your condition – yourself, a spouse or other family member, or your doctor – can start the pre-admission certification process. It starts by calling INTRACORP *before* you check in.

It's important to follow the right procedures since failure to notify INTRACORP will result in a \$400 penalty that you must pay. (This penalty does not count toward your annual out-of-pocket maximum.)

#### *Why It's Important*

Many treatments that required lengthy hospital stays in years past can now be successfully completed in a few days or sometimes without any hospital stay at all. The sooner a patient is home from the hospital, the more quickly he or she can get back to a normal routine of daily activity.

#### *How It Works*

INTRACORP registered nurses and other trained staff conduct pre-admission certification, working closely with your doctor. They review each upcoming hospital stay before it occurs, making sure the hospital is the best setting for treatment and verifying that the recommended course of treatment is the most effective.

INTRACORP routinely certifies the large majority of hospitalization requests. In some cases that require further review or clarification, an INTRACORP consultant physician will contact your doctor to better understand the details of your situation. INTRACORP will never deny certification for an admission without first discussing the situation with your doctor.

#### *In an Emergency*

When you have a medical emergency, it's important that you seek medical attention first. If you're admitted to the hospital due to the emergency, you or your doctor should notify INTRACORP and certify your admission within 72 hours.

## The Medical Plan

### *If You're Expecting a Child*

Call INTRACORP by the end of the third month of pregnancy to certify the upcoming hospital stay. During the pre-admission certification call, the INTRACORP representative will ask a few questions to determine if there's any particular risk associated with the pregnancy. If so, you'll learn more about a recommended treatment plan that addresses such risks.

### *CIGNA's Healthy Babies Program*

The Healthy Babies program provides education on a variety of topics associated with the expectant mother's and baby's health during a pregnancy. Your doctor or CIGNA Member Services can tell you more about the program and how it can help.

### **Continued Stay Review**

Continued stay review is a process INTRACORP uses to verify that a continued hospital stay is the most effective treatment. It's different from pre-admission review because it takes place after the hospital admission occurs and focuses on whether additional days are appropriate.

When your doctor needs to extend your hospital stay beyond what was previously certified, he or she should contact INTRACORP to discuss your continued stay, since any uncertified days in the hospital result in a \$400 penalty.



Pre-admission certification and continued stay review requirements apply to hospital stays in the United States. For hospital stays outside the U.S., the Plan relies on other clinical guidelines that apply to the country where the hospital stay occurs, to make sure that hospital stays are appropriate. Contact the Insurance Section should you need to be hospitalized.

### **Case Management**

#### *How it Can Help*

If you or one of your covered family members need medical treatment for a serious condition, case management can help. When you're coping with a serious illness, 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.

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

## The Medical Plan

INTRACORP provides this service at no cost to you.

### *How to Get Started*

You, one of your family members, or your doctor can start the process with a phone call to INTRACORP. Once INTRACORP understands your particular situation, you're assigned a Case Manager.

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

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

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

### **Pre-Existing Conditions**

A pre-existing condition is any diagnosed illness, injury, or other condition that you (or one of your covered family members) received treatment for before you were covered by the IDB Medical Plan.

The IDB Medical Plan pays a maximum of \$750 in benefits for pre-existing conditions, during the first 12 months of coverage.

However, there are some exceptions to this rule that may increase benefits for you, your spouse and your covered dependent children. Your expenses relating to a pre-existing condition will be treated as regular Medical Plan expenses *after the earlier of:*

- 90 days, *during* which you're covered under the Medical Plan, you receive no treatment, incur no expenses, and receive no diagnosis related to the pre-existing condition,

OR

- One year (or five years for sponsored dependent parents), *during* which you're continuously insured for benefits relating to the pre-existing condition.

### *Prior Creditable Coverage*

Your waiting period for receiving benefits in connection with a pre-existing condition may be reduced if you can show proof of "prior creditable coverage." Prior creditable coverage means a period of time when you were covered for a pre-existing condition under another health plan.

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If you believe you have prior creditable coverage that would reduce the waiting period under the IDB Medical Plan, you can receive your coverage “credit” by presenting a certificate of prior group health coverage to the IDB Insurance Section.



Prior creditable coverage can apply to a pre-existing condition for you, your spouse or your covered dependent children. It does **not** apply to covered dependent parents.

### An Overview of Medicare

If you (or any of your covered dependents) are eligible for Medicare benefits because of age or any other reason, you should know about how Medicare works with the IDB Medical Plan.

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

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

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

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

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

#### *Reimbursement of Part B Premium*

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

If you are receiving a monthly Social Security payment from the U.S. government, your Medicare Part B premium is being deducted from that payment on a monthly basis. Upon

## The Medical Plan

receipt of your Medicare card copy, you will be reimbursed the current Medicare Part B premium on a monthly basis.

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

### *Where to Find More Information*

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

There's a toll-free number sponsored by the U.S. Government, 1-800-MEDICARE (1-800-633-4227). Once you're connected, you can initiate the enrollment process, order publications about Medicare, or hear pre-recorded information in English or Spanish.

### **How IDB Benefits Coordinate with Medicare Medical Benefits**

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

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

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

### *Using Non-Participating Medicare Providers*

Most doctors participate in the Medicare program. If you are Medicare-eligible but your doctor doesn't participate in the Medicare program, the IDB Medical Plan reimburses your eligible expenses as if you weren't eligible for Medicare benefits.

### **Have a Question?**



*Q: How can I find out more about my Medicare eligibility and benefits?*

**A:** You can reach Medicare by phone at 1-800-MEDICARE. If you have access to the Internet, visit <http://www.medicare.gov>.

## The Prescription Drug Plan



The Prescription Drug Plan covers medication your doctor prescribes that (a) requires a written prescription in the U.S., and (b) that's been approved by the U.S. Food and Drug Administration. In this Section, you'll see more about how the program works, and how you can keep your prescription costs low.

### How the Prescription Drug Plan Works

The Prescription Drug Plan includes coverage for brand-name and generic drugs. The Plan includes "mandatory generic substitution." This means that, when your prescription is available in both a brand-name and generic form, your pharmacist will automatically give you the generic form.

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

### Have a Question?



*Q: Brand-name or generic — what's the difference?*

*A: A generic drug is one that contains the same ingredients and provides the same therapeutic benefits as the equivalent, higher-cost brand-name drug. **Generic drugs become available when brand-name drug patents expire.***

### *Purchasing Your Prescriptions at a Pharmacy*

When you get your prescriptions at a pharmacy that's part of CIGNA's "RxPrime" network, you show your Medical Plan ID card and pay only a "co-payment". A co-payment is a fixed dollar amount you pay for your prescriptions.

If you're in the U.S., you'll find that most of the big pharmacy chains are part of the RxPrime network. You can go to any pharmacy you wish, but your costs are much higher when you use a pharmacy that's not part of the RxPrime network. CIGNA Member Services can tell you which pharmacies are in the network. You can also find out by visiting <http://www.cigna.com>.

### *Purchasing Your Prescriptions by Mail Order*

CIGNA's affiliate, "Tel-DRUG" provides a mail order option when you have prescriptions for medications you need regularly to treat an ongoing condition. When you use Tel-DRUG, you'll get a larger supply of your prescription and there's no co-payment.

## The Prescription Drug Plan

To use the mail order option, start by contacting Tel-DRUG at 1-800-TEL-DRUG. Tel-DRUG representatives will help you work through all the details. You can also log on to <http://www.teldrug.com> or the insurance web site and follow the prompts for information about mail order.

If you're outside the U.S., the mail order option is not available, since U.S. laws don't allow drug vendors to mail prescription drugs overseas.

### *Purchasing Your Prescriptions in Other Countries*

No matter where you are, you're covered for prescription drugs. You simply purchase your medication and file a claim. Please refer to the section on "How To File a Claim" for specifics on submitting expenses to the insurance company.

### Your Prescription Drug Benefits

The chart below shows your benefits under the Prescription Drug plan. In the U.S., your share of the drug cost depends on (a) whether it's generic or brand-name and (b) whether you use a network pharmacy.

At pharmacies, your prescription will include up to a 30-day supply. When you use the Mail Order program, your prescription will include three times as much, up to a 90-day supply.

	In-Network		Out-of-Network	
	Generic	Brand-name	Generic	Brand-name
<i>At a U.S. pharmacy: when DAW is specified</i>	NA	\$10	50% of the total cost	
<i>At a U.S. pharmacy: when DAW is not specified</i>	\$5	\$10 <i>plus</i> the difference between the generic and brand-name drug cost		
<i>Through Mail Order.</i>	\$0	\$0	Not available	
<i>Outside the U.S.:</i>	\$5	\$5	NA	

### How DAW Works

At U.S. pharmacies, your co-payment is lowest (\$5) when you purchase generic drugs. For a brand-name drug, your co-payment is \$10 if your doctor indicates "DAW" on the prescription order form that you present to the pharmacist.

## The Prescription Drug Plan

When the pharmacist sees “DAW”, he or she knows to fill the prescription exactly as the doctor has instructed, with no generic substitution.

If your doctor hasn't indicated DAW on the prescription order form, the pharmacist will fill the prescription with a generic drug equivalent (if one is available) and you'll pay only \$5.

If you don't want a generic drug and prefer to purchase the brand-name drug, you'll pay a \$10 co-payment plus the cost difference between the generic drug and the brand-name drug. Here's an example to show how it works:

*John has a choice between a brand-name drug, which costs \$50, and a generic drug that costs \$25. John's doctor didn't indicate “DAW,” but John still wants the brand-name drug. Here's what he'll pay:*

\$10	+	\$25	=	\$35
the regular brand-name drug co-payment		the cost difference between the \$50 brand-name cost and the \$25 generic cost		John's total co-payment

Remember that the DAW provision applies to prescriptions you purchase at U.S. pharmacies and through mail order. DAW doesn't apply to prescription drugs purchased outside the U.S.

### Vacation Supplies

If you're planning a vacation and will be unable to refill your prescriptions while you're away, you may request a larger supply of your medications. You or your pharmacist can contact RxPrime to make the request.

A vacation supply includes up to a 90-day supply. For generic drugs, the vacation supply co-payment is \$5 for each 30-day supply. For brand-name drugs, the vacation supply co-payment is \$10 for each 30-day supply.

If your stay outside the U.S. will be for an extended period, Tel-DRUG can provide up to a six-month supply, as long as your doctor provides documentation of your need for the prescription during the period you'll be away.

Vacation supplies are only available to purchases made in the U.S.

## The Prescription Drug Plan

### What's Not Covered

The Prescription Drug Plan **DOES NOT** pay for:

- Experimental drugs or substances not approved by the U.S. Food and Drug Administration, or other national authority where your treatment occurs
- Drugs labeled, "Caution – Limited by Federal Law to Investigational Use"
- Over-the-counter drugs
- Smoking cessation products
- Prescription vitamins, except prenatal vitamins and certain vitamins that are part of cancer treatment.

### Have a Question?



*Q: Where do I call if I have a question or problem with a prescription drug claim?*

**A:** Call RxPrime. You'll find the number on the back of your Medical Plan ID card.

## The Vision Plan



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

### What's Covered

To receive vision care benefits, you can go to the licensed provider of your choice. You and each of your covered dependents receive benefits for:

- Eye exams, and
- New frames and lenses, or contact lenses

### Frequency of Your Benefits

All your Vision Plan benefits apply for a 24-month period. So, every 24 months, you'll be covered for a new eye exam. It works the same way for frames, lenses, and contact lenses.

Once you receive a Vision Plan service, you'll need to wait 24 months before the plan will pay benefits for the same services again.

### Receiving Your Benefits

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

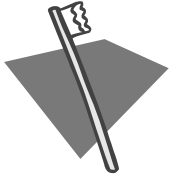
When you submit your expenses to CIGNA, here's what the plan pays:

For eye exams:	\$60 toward the total cost
For frames and lenses <b>or</b> contact lenses:	\$140 toward the total cost

There's no deductible, and no coinsurance. Just submit your eligible expenses and you'll receive your Vision Plan reimbursement.

Cigna also has a network of eyewear providers who offer exams, eyewear and contacts at discount rates. The use of these providers will lower the amount not reimbursed by the vision benefit. Additional information and a provider directory can be found under Healthy Rewards at the Cigna website: [www.cigna.com](http://www.cigna.com).

## The Dental Plan



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

### How the Dental Plan Works

The Dental Plan provides the same benefit levels whether you use an in-network or out-of-network dental provider. Benefit levels are also the same inside and outside the U.S.

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

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

For each type of covered service you need, the plan pays a percentage of the total cost, and you pay no deductible.

Below, you'll find a chart that provides more details on covered services, and the percentage of the total cost that the Dental Plan pays for eligible charges.

<i><b>When you need:</b></i>	<i><b>The Dental Plan pays:</b></i>	<i><b>You pay:</b></i>
<p><b>Preventive and Diagnostic Care</b>, such as:</p> <ul style="list-style-type: none"> <li>■ Routine exams and cleanings (2 per year)</li> <li>■ Full-mouth x-rays (every 3 years)</li> <li>■ Bitewing x-rays</li> <li>■ Panoramic x-rays (every 3 years)</li> <li>■ Fluoride application (each year for those under 19)</li> <li>■ Sealants (each year for those under 19 – posterior teeth only)</li> <li>■ Space Maintainers (for non-orthodontic treatment only)</li> <li>■ Emergency Care (for pain relief)</li> </ul>	100%	0%
<p><b>Basic Restorative Care</b>, such as:</p> <ul style="list-style-type: none"> <li>■ Fillings</li> <li>■ Root canal therapy</li> <li>■ Periodontal scaling and root planning</li> <li>■ Denture adjustments and repairs</li> <li>■ Extractions</li> <li>■ Anesthetics</li> </ul>	80%	20%

## The Dental Plan

<b>Major Restorative Care</b> , such as: <ul style="list-style-type: none"> <li>■ Crowns</li> <li>■ Dentures</li> <li>■ Bridges</li> </ul>	50%	50%
<b>Oral Surgery</b> , such as: <ul style="list-style-type: none"> <li>■ Surgical extractions</li> <li>■ Frenectomy</li> <li>■ Osseous surgery</li> <li>■ Implants</li> </ul>	100%	0%
<b>Orthodontics</b>	50% (up to \$2,500 lifetime maximum)	50%



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

### Benefit Maximums

For most covered services, your benefit maximum is an annual dollar limit — \$1,600 in years 1 and 2, then \$3,200 for each year after. This limit renews each calendar year.

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

### Pre-Determination of Benefits

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

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

## The Dental Plan

### Coverage for Accidental Damage to Your Teeth

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

### When Services Begin

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

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

These services fall into a different category because, by their nature, they often require other related services that CIGNA considers part of the same treatment.

### What's Not Covered

The Dental Plan **DOES NOT** pay for:

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

## The Dental Plan

### Have a Question?



**Q:** *Are my dental benefits greater if I use CIGNA preferred providers?*

**A:** If you use a CIGNA network dentist, the plan pays the same percentage of eligible charges, but your out-of-pocket costs may be lower. Network dentists often discount their rates, and if your dentist's rates are lower, the portion of the cost that you owe will be lower too.

## How to File a Claim

### *Medical/Dental Plans*

These plans offer in-network and out-of-network benefits. If you use one of CIGNA's network providers, you do not need to submit a claim because your provider will automatically submit it on your behalf.

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

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

### *The Prescription Drug Plan*

When you use CIGNA's network pharmacies, you do not need to submit a claim.

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

There may be occasions when, due to travel, an emergency, or a special situation, you may have to use a non-network pharmacy. In these cases, you'll need to file a paper claim with RxPrime to receive reimbursement. You may obtain a claim form from the Insurance Section. This is only for prescriptions purchased in the U.S., regardless of where you reside. Mail the RxPrime claim form and your original prescription receipts directly to the address on the claim form.

### *The Vision Plan*

This plan is not a network plan, so you'll need to submit a claim each time you receive vision plan services. See below for instructions on how to file claims for out-of-network services.

## **Out-of-Network Claims**

For all non-network services, you'll need to submit a claim form. You may be required to pay the full cost of services when you receive them and then receive reimbursement after you file your claim.

## How to File a Claim

### Where to Submit Your Claims

*For Headquarters Staff and Retirees Who Reside in the United States*

File with CIGNA Healthcare, using the appropriate claim form, when you use out-of-network providers or when you use providers outside the United States.

*For International Staff and Retirees Who Reside Outside the United States*

Submit all reimbursement claims for Medical, Prescription Drugs, Vision, and Dental plan expenses to CIGNA International, using the appropriate claim form.

You can mail your claims to CIGNA at the address listed on the claim form. Or, you can send them to the IDB Insurance Section, which will promptly forward them to CIGNA. From the Bank's member countries, you have the additional option of sending claims through the Country Office.



Always use the I.D. number shown on your card, even though some forms ask you for your Social Security number.

Keep copies of your claims and supporting documentation until you or the provider has received reimbursement.

### Deadline for Submitting Claims

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.

### Explanation of Benefits (EOBs)

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

## How to File a Claim

### Special Provisions

#### *Payment to Minors*

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

#### *If You Die Before Receiving Reimbursement*

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

#### *The Bank's Liability*

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

### Have a Question?



**Q:** *Where do I call with questions about the claims that I submit?*

**A:** When you have questions about the status of an unpaid claim, or an amount paid, or about anything you see on your Explanation of Benefits form, call CIGNA or go to MYCIGNA.COM.

In the handbook section titled, "Useful Contacts," you'll find the telephone numbers you need. When you call, have your ID card handy and let the CIGNA representative know your company is the Inter-American Development Bank.

It's a good idea to keep notes, including the date you call, the name of the representative that helps you, and the information you receive. Keeping track of this information can be very helpful if you find there's a need for follow-up.

## CIGNA Careline



This section presents an overview of the CIGNA Careline and the services it provides.

### What the Careline Provides

The CIGNA Careline is a free medical advisory service available to you by telephone. Available through INTRACORP, the CIGNA Careline provides you with a valuable resource for many health and medical-related questions and concerns.

When you call the Careline you will reach a Registered Nurse (R.N.) who can answer general questions and help you:

- Understand treatment plans, medical terminology and diagnostic tests
- Locate physicians, hospitals and other health care services
- Decide what to ask your physician if you are concerned or confused about a treatment or diagnosis
- Understand the side effects of certain medications
- Understand hospital pre-admission certification needs.

Also, the CIGNA Careline R.N. you speak with can send you additional information about preventive care and treatment for common health conditions.

All calls are confidential.

### *Finding Network Providers*

The Careline is also a resource for locating PPO providers while you're at home or while you're away. If you are traveling, you can call the Careline for names of participating providers in other network areas. The CIGNA Careline personnel have access to up-to-date information. However, because the network of participating providers changes frequently, it is a good idea to call the provider to confirm that he still participates in the CIGNA PPO network before making an appointment.

### How to Reach the Careline

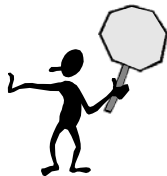
The CIGNA Careline is simple and easy to use and it is available 24 hours a day, 7 days a week. Just call the toll-free number on the back of your Medical Plan ID card. Once you're connected, follow the voice prompts to reach the Careline.

## **CIGNA Careline**

### **What the CIGNA Careline Does Not Provide**

The CIGNA Careline offers a wide range of helpful information. However, Careline personnel cannot answer specific questions about your medical coverage or claims, provide medical opinions, comment on the competency or reputation of a provider, prescribe medication, give diagnoses, or provide advice about treatment.

## General Limitations and Exclusions



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

### What the Program Doesn't Cover

The plans included in the Program don't cover:

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

### IDB Health Plan Coverage vs. Auto Insurance Coverage

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

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

## General Limitations and Exclusions

### Subrogation

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

In this situation, if an IDB plan and a third party both pay expenses for you or one of your covered dependents, a process called "subrogation" will begin. Subrogation is a legal process that entitles the IDB 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, IDB may need you to provide any information and paperwork related to the expenses you incur because of the illness or injury caused by the third party.

## Coordination of Benefits

### When You Have Other Insurance Coverage

This section describes how the IDB 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're covered by the IDB plans and also by another outside plan or program – for example, the medical plan of your spouse's employer – the IDB plan will “coordinate” benefits with those other plans.

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

### Primary and Secondary Benefits

When two or more plans coordinate benefits, one plan pays first. To determine which plan pays first, IDB 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.

#### *When an IDB Plan is Primary*

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

#### *When an IDB Plan is Secondary*

When the benefit determination rules indicate that an IDB plan is secondary, IDB 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.

### A Closer Look at the Benefit Determination Rules

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

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

In certain cases, there are exceptions to this rule:

## Coordination of Benefits

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

### ■ Court rulings

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

### ■ Length of dependent coverage

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

In certain cases there are exceptions to this rule:

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

The following definitions have special meaning in benefits coordination rules:

- "Plan" means any of the following that provides medical, dental, or vision benefits or services:
  - Group or blanket insurance coverage, other than group school accident policies

## Coordination of Benefits

- Service plan contracts, group or individual practice or other pre-payment plans
- Coverage under any labor management trustee plans,
- Union welfare plans
- Employer organization plans
- Employee benefit organization plans

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

- “Allowable Expense” means any necessary, reasonable, and customary term of expense that’s covered, in full or in part, by any one of the plans that covers the person for whom the claim is made. When the benefits from a plan are in the form of services rather than cash payments, the reasonable cash value of each service is considered both an allowable expense and a benefit paid.

“Allowable expense” does not include the difference between the cost of a private room and the cost of a semi-private room, except when the person’s stay in a private room is considered medically necessary according to generally accepted medical practices.

## Glossary of Benefit Terms

**Accelerated Benefits** — Life insurance plan benefits payable prior to death, in the event of terminal illness.

**Beneficiary** — The person(s) you designate to receive life insurance plan benefits in the event of your death.

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

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

**“Careline”** — A free CIGNA telephone service, staffed by Registered Nurses, that provides resources for many health and medical-related questions and concerns.

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

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

**Continued Stay Review** — INTRACORP’s process for ensuring that a continued hospital stay is the most effective setting for medical treatment. It takes place after you’re admitted and focuses on whether additional days in the hospital are appropriate.

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

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

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

**Coverage Reduction Schedule** — A table illustrating how life insurance benefit amounts reduce beginning at a specified age.

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

## Glossary of Benefit Terms

**Deductible** — An annual amount you must pay for out-of-network services before the medical plan pays benefits for eligible expenses.

**Disability** — A condition, including accidental injury, sickness, mental illness, substance abuse, or pregnancy that limits or prevents you from working.

**Elimination Period** — The six-month wait between the date you first become totally disabled and the date your LTD plan benefits begin.

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

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

**Flat-dollar Benefit** — A specific life insurance coverage amount that's not variable and not related to your earnings.

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

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

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

**Hospice** — A health care facility or service providing medical care and support services to terminally ill individuals and their families.

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

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

**Net Annual Salary** — The portion of your total compensation covered under the IDB life insurance and long-term disability plans, including basic rate of pay but *not* including overtime, bonus, tax reimbursement or any other form of additional compensation.

## Glossary of Benefit Terms

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

**Out-of-Pocket Maximum** — An annual individual or family limit on the amount you spend out of your own pocket for medical plan expenses that the plan doesn't cover in full.

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

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

**Portability** — A feature of the supplemental life insurance plans that allows you, upon termination of employment at IDB, to keep your coverage at the same level without submitting additional proof of good health. After you leave IDB, you make premium payments directly to the insurance carrier.

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

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

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

**Principal Amount** — Under the AD&D plans, the amount of coverage that applies to you. Certain AD&D benefits are calculated as a percentage of your principal amount. If you elect supplemental AD&D, coverage amounts for your family are based on your principal amount.

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

**Proof of Good Health** — Sometimes called, "Evidence of Insurability," is medical information you provide to your life insurance carrier when you want coverage that exceeds the Guarantee Issue amount.

## Glossary of Benefit Terms

**Reasonable and Customary (R&C)** — The average prevailing cost in a particular geographic area for medical plan services. Insurance companies submit claim data to the Health Insurance Association of America. They in turn tabulate the cost of each medical procedure in every generalized zip code area. Our plan then uses the 90<sup>th</sup> percentile as the R&C limit. This means that 90% of the providers in the generalized zip code area charge the R&C limit or less.

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

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

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

**Totally Disabled** — A condition that results from accidental injury, sickness, mental illness, substance abuse, or pregnancy that causes you to be unable to perform any of the duties of your job.

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

# Premium Rates

## Active Participants – Life Insurance

- Basic Life The contribution of the employee toward this coverage is \$.055 cents for each \$1,000 of coverage per month. Coverage under basic life insurance includes Long Term Disability, Basic Accidental Death and Dismemberment and Dependent Life Insurance.

Example

Salary.....\$68,235 per year

Benefit.....\$102,352.50 rounded up equals \$103,000

Cost.....\$103,000 times \$.055 cents per \$1,000 equals \$5.67 per month.

- Supplemental The contribution toward this coverage for either the employee or the spouse is based on age. The cost is the rate per \$1,000 of coverage as shown in the following table.

Age Band	Rate/\$1,000
0-24	0.20
25-29	0.20
30-34	0.21
35-39	0.22
40-44	0.24
45-49	0.26
50-54	0.38
55-59	0.50
60-64	0.68
65-69	1.42
70 and above	2.34

Example

Benefit Selected .....\$100,000

Age .....42

Cost.....\$24.00 per month (100 times .24 cents)

- Supplemental Accidental Death and Dismemberment The contribution towards employee coverage is \$.02 cents per \$1,000 of coverage ; or \$.03

## Premium Rates

cents per \$1,000 of coverage for the family. The following table illustrates these costs.

Employee Benefit	Monthly Cost	
	Employee Only	Family
\$20,000	\$0.40	\$0.60
\$40,000	\$0.80	\$1.20
\$60,000	\$1.20	\$1.80
\$80,000	\$1.60	\$2.40
\$100,000	\$2.00	\$3.00
\$120,000	\$2.40	\$3.60
\$140,000	\$2.80	\$4.20
\$160,000	\$3.20	\$4.80
\$180,000	\$3.60	\$5.40
\$200,000	\$4.00	\$6.00
\$220,000	\$4.40	\$6.60
\$240,000	\$4.80	\$7.20
\$260,000	\$5.20	\$7.80
\$280,000	\$5.60	\$8.40
\$300,000	\$6.00	\$9.00
\$320,000	\$6.40	\$9.60
\$340,000	\$6.80	\$10.20
\$360,000	\$7.20	\$10.80
\$380,000	\$7.60	\$11.40
\$400,000	\$8.00	\$12.00
\$420,000	\$8.40	\$12.60
\$440,000	\$8.80	\$13.20
\$460,000	\$9.20	\$13.80
\$480,000	\$9.60	\$14.40
\$500,000	\$10.00	\$15.00

### Retired Participants – Life Insurance

- ❑ Low Option – No cost
- ❑ High Option - The contribution of the retiree toward this coverage is \$0.50 cents for each \$1,000 of coverage per month. At age 62 this rate is locked in for the next 10 years. At age 72, no additional premium will be taken.
- ❑ High Option Spouse – \$2.90