Information contained in this summary does not imply or form a contractual arrangement. The summary is only intended to provide an AIARC participant with jargon-free general information about the medical insurance plan administered by AIARC and does not cover every exception or possibility. Further, the information does not in any way override the plan rules and the policy documents between AIARC and the plan provider, which constitute the legal documents that govern the operation of the medical plan. The medical plan rules and policy documents will prevail in the event of any conflict, as the plan rules and policy documents are controlling. Information contained in this summary can change at any time for any reason. Additionally, nothing in this summary should be construed as establishing an employer-employee relationship between a participant and AIARC.
# 2017 IARC Medical Plan Benefit Summary

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Overview
This is a summary of the benefits provided by the International Agricultural Research Centers Medical Plan (referred to as “the Plan”) to active employees and retired participants from Centers who are members of the Association of International Agricultural Research Centers (AIARC). The Plan covers expenses for a range of health-care services and supplies including medical, vision, prescription drugs, and dental care. Please note that retired participants are not eligible for dental coverage. For the most up-to-date information, please refer to the aiarc.org website.

AIARC’s Role and Plan Partners
To manage the IARC Medical Plan and other employee benefits, the IARC Centers pooled resources to form the Association of International Agricultural Research Centers (AIARC), a nonprofit organization located in Alexandria, Virginia, USA. AIARC provides day-to-day service and support to the Centers, which includes financial accounting and recordkeeping, resolution of claim issues, vendor management, legal research, employee communication, and vendor bids and renewal negotiations. AIARC’s activities are monitored by a Board of Directors composed of representatives from participating Centers.

As an IARC Medical Plan participant, you will deal directly with the following vendors chosen by the Board to provide plan services:

- Cigna (formerly Vanbreda International), based in Antwerp, Belgium, is responsible for administering medical, dental, and prescription-drug claims for the Plan’s participants.
- Cigna partners with Cigna Healthcare (Cigna) in the U.S. to provide the Plan’s U.S. Open Access Plan (OAP) provider network and managed care services.
- Cigna Healthcare (Cigna) handles claims for outpatient prescription drugs received in the U.S.

Eligibility, Enrollment, and Termination

Active Employees

Eligibility
You are eligible for coverage if your Center participates in the Plan and you meet one of the following employment criteria:

- A full-time employee working your Center’s normal work week.
- A part-time employee working at least 20 hours a week or 50% of your Center’s normal work week and expected to work at the Center for at least one year.
- A long-term consultant contracted to work for a participating Center for at least a year.
- A short-term employee or consultant contracted to work for a Center less than a year.
- A visiting scientist working temporarily at a Center.
- A trainee/student in a Center’s training/educational program. Coverage is limited to two months or less.*
- A very short-term employee working for two months or less.*
- A member of the Board of Directors or Board of Trustees of an IARC Center. This coverage is limited to the time the member is attending Board meetings, unless the member qualifies for another reason (e.g., as a full-time employee).*

* Individuals who qualify as trainees/students, very short-term employees, or as members of a Center’s Board of Directors or Board of Trustees are not eligible for the dental and vision benefits. Contact your Center for more details about eligibility guidelines and restrictions.
Enrollment and Effective Date
Upon your hire, your Center will provide you with an [IARC Insurance Plan Enrollment Form]. Once you are enrolled in the Plan, Cigna will provide a personalized Cigna ID card (which includes medical, dental, and prescription drug plan information) for you and for each of your dependents. The card(s) will be sent to your Center for distribution.

If you are a full-time employee, a part-time employee, or a long-term consultant, Plan coverage becomes effective 5 days prior to your official date of employment at your Center. If you are a short-term employee, short-term consultant, visiting scientist, trainee/student, or very short-term employee, your coverage becomes effective on the official date of employment. Coverage for members of a Center’s Board of Directors or Board of Trustees is effective based on dates as determined by the Center. The effective date of coverage for your current dependents will be the same as yours.

**Important:** If a new participant does not submit a completed enrollment form within 25 days of his or her normal effective date, the effective date will be deferred to the first day of the month following approval. In addition, the late enrollee may be subject to a $4,000 limit on the amount that the Plan will pay in the first year of coverage for pre-existing medical conditions. See the Pre-existing Condition Limitation section of this Summary. However, you can postpone enrollment without penalty if you have existing coverage under another medical plan at the time of your normal effective date. You must complete the medical opt-out section of the enrollment form that states you are declining coverage in the IARC Plan and complete the Waiver of Insurance Form.

Termination of Coverage
If you are a full-time employee or long-term consultant, Plan benefits for you and your dependents will cease 25 days following the day you terminate employment from your Center. Coverage for members of a Center’s Board of Directors or Board of Trustees ceases at the discretion of the Center. For other participants, coverage ceases on the day you no longer meet the Plan’s eligibility requirements.

Bridging and Retired Participants

Eligibility for Bridging Coverage
To qualify for bridging insurance, you must have worked for an AIARC member Center for at least the two most recent years immediately prior to termination and have participated in the IARC Medical Plan for those two most recent years.

Eligibility for Retiree Coverage
To qualify for retiree insurance, you must be at least 55 years old, have worked for an AIARC member Center, and have participated in the IARC Medical Plan for at least 10 years including the five consecutive years immediately prior to your retirement.

If you qualify for both options, you can only choose one option upon your separation. For example, if you choose bridging insurance, you will not be eligible for retiree insurance at a later date, and vice versa. To continue coverage under bridging or retiree insurance, you will pay the premiums directly to your Center based on the agreement between you and your Center. For legal reasons, AIARC can only collect premium payments from the Centers.

Retired Participants (65 years of age or older) residing in U.S.
Retired participants who reside in the United States and are 65 years of age or older, must enroll in Medicare Parts A and B. To find out if you are eligible for Medicare Parts A and B, contact the Social
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Security office at 1-800-772-1213 within the United States or visit the Social Security website at www.socialsecurity.gov. Please refer to the U.S. Medicare and Medicare Supplements (Medigap) eligibility worksheet to determine if a Medicare Plan is cheaper for you than remaining in the IARC Plan.

After you have been accepted for Medicare, you must immediately notify AIARC. This notification can be made by sending a copy of your Medicare eligibility letter from the Social Security office or a copy of your Medicare card. Your IARC medical premium will be discounted only after a copy of the Medicare letter or card is received by AIARC. You will only receive the discount going forward after the notification is received by AIARC. There will be no retroactive premium adjustment, no matter if the Medicare eligibility date is earlier than the date of notification to AIARC.

Enrollment and Effective Date
Your Center will provide you with an IARC Insurance Plan Change Form and a new Tax Residency self-Certification Form to change your coverage to bridging or retiree status for the IARC Medical Plan. Your medical insurance coverage will continue for a period of 25 days (the grace period) after you end your employment and your bridging or retiree insurance will begin on the first day after the 25-day grace period. You can continue using your existing Cigna ID card.

Important: If you fail to submit a completed IARC Insurance Plan Change Form and a new Tax Residency Self-Certification Form within 25 days after your last day of coverage as an active employee, you will lose the right to participate in the bridging or retiree insurance. You may not join at a later date.

Termination of Coverage
Insurance for bridging or retiree coverage will terminate on the earliest of:

- The first of the month for which you did not pay the required premium,
- The date you notify your Center that you no longer wish to participate in the Plan, or
- The last day of the month in which you die.
- Bridging insurance will automatically terminate 365 days from the date that coverage begins.

Dependents

Eligibility for Dependents
Your dependents are also eligible for Plan coverage to include your spouse or domestic partner, and your eligible children. An eligible child must:

1) be younger than age 26;
2) be biologically related to or adopted by you or your spouse or domestic partner;
3) live with you or maintain the same permanent address as you; and,
4) receive more than half of his or her support from you.

If the spouse or domestic partner has a biological or adopted child from a previous relationship, this child is eligible for coverage as long as the Center’s employee or retiree remains in this marriage or domestic partnership. If the Center’s employee or retiree ends his or her relationship with the spouse or domestic partner, only a child who is biologically related or legally adopted by the Center employee or retiree will remain eligible for coverage.

A child attending university away from home is considered to live at the same permanent address as the Center employee or retiree.
Please note that no one can be covered as both an employee and a dependent, and no child can be covered as a dependent of more than one employee. If the employee dies, his or her dependents can remain eligible by paying the required premium.

**Eligibility for Domestic Partnerships**

The AIARC Board understands that there is political and philosophical debate on the issue of domestic partnerships within member Center countries. The Plan’s contract does not react to these debates, nor does it affirm the validity of same-sex marriage or domestic partnerships. The IARC Plan follows and acts upon the determination of the family status made by each member Center. As such, each member Center must determine its own definition of and documentation for domestic partnership, recognizing the laws of the country within which it operates.

Generally, the following criteria are applied by a Center if it chooses to recognize domestic partnerships:

- The parties are not related by blood to a degree that would bar marriage where the parties reside;
- The parties are not married to anyone else;
- The parties are each other’s sole domestic partner and intend to remain so indefinitely;
- The parties are legally competent to contract and of lawful age to marry;
- The parties have resided together in the same residence for at least 12 months and intend to do so indefinitely; and,
- The parties have been jointly responsible to each other for basic living expenses and welfare for at least 12 months.

**Enrollment and Effective Date**

If you are covered by the Plan and acquire a dependent who meets the Plan’s eligibility rules, you have 25 days to enroll the new dependent without penalty. In the event of marriage, new coverage is effective on the later of the date of marriage or the date you submit the enrollment form for your spouse. New coverage for children is effective on the date of birth, adoption or placement for adoption. In cases of domestic partnership, new coverage for your partner (and their eligible dependents) is effective upon the date of approval by your Center.

You must also notify your Center within 25 days if you drop a dependent from the Plan. Your initial enrollment forms and subsequent change forms must be authorized by your Center and submitted to AIARC.

**Termination of Coverage**

Coverage for your dependents ceases on the earlier of the date your own coverage ends or on the date they no longer meet the eligibility requirements of the Plan. If you die, your eligible dependents can continue their coverage by paying the Plan’s premium rates for their coverage.

**Pre-Existing Condition Limitation**

If a new participant (employee or dependent) does not submit a completed enrollment form within 25 days of becoming eligible for the Plan, the Plan will limit claim payments for pre-existing medical conditions to $4,000 during the first 12 months in the Plan.

The 12-month period for the pre-existing condition limitation is lowered by any time the new participant was covered by another medical plan immediately prior to enrolling in the IARC Plan. For instance, if a new employee had been covered for 10 months under his or her prior employer’s medical plan, the $4,000 pre-existing condition limitation will apply for only the first two months under the IARC Plan. If you
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were covered under another medical plan for more than a year immediately prior to joining the IARC Plan, there is no limitation on pre-existing conditions.

If you are continuing insurance under the bridging or retiree option, the pre-existing condition applies to dependents that you add to the Plan after bridging or retiree coverage has begun.

A pre-existing condition is an injury or disease for which a person received treatment, services or medicines in the 12-month period immediately prior to Plan enrollment. This limitation does not apply to pregnancy, or to a newborn or adopted child.

How Your Plan Works

Medical
Your plan design is based on whether you or your Center is paying non-U.S. premium rates or U.S. premium rates on your behalf. If you or your Center is paying non-U.S. premium rates, you will be enrolled into the International Plan. If you or your Center is paying U.S. premium rates, you will be enrolled into the U.S. Plan.

International Plan (for those paying non-U.S. rates)
This section applies only to active employees and retired participants paying international rates (non-U.S. premium rates).

For care received outside the U.S., the Plan generally pays 90% of your expenses after you satisfy the Annual Deductible. You can minimize your costs by using a provider in Cigna’s network of preferred providers. Cigna has negotiated attractive fees with these providers, so while the Plan pays 90% of covered expenses for all providers outside of the U.S., your portion of costs will be lower if you use providers in Cigna’s network. Additionally, network providers have direct-billing arrangements with Cigna, which minimizes your paperwork. You can access the Cigna network providers via the aiarc.org website.

For care received in the U.S., the limit on your Out-of-Pocket expenses is higher. However, the Plan pays a higher percentage of your U.S. expenses if you use the providers who are members of Cigna’s Open Access Plan (OAP) network. Cigna’s OAP network providers have agreed to discounted fees, so by using them you will be paying a lower percentage of a lower charge. The OAP providers have direct-billing arrangements with Cigna, which facilitates the claims process. You can access the Cigna OAP providers via the aiarc.org website.

Medical Plan Care Summary Table (for those paying non-U.S. rate)
The following table provides the basic medical plan design for active employees and retirees paying international rates (non-U.S. rates).

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<th>Medical Care</th>
<th>Care Received Outside U.S.</th>
<th>Care Received in U.S.</th>
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</thead>
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<td>International Plan (paying non-U.S. premium rates)</td>
<td>Any Provider</td>
<td>CIGNA OAP (In-Network)</td>
</tr>
<tr>
<td>Annual Deductible*</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>Per Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$400</td>
<td>$600</td>
</tr>
<tr>
<td>Hospital Deductible*</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance (Plan Pays)</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>(Applies to Medical Claims, except Preventive Care)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Medical Care</th>
<th>Care Received Outside U.S.</th>
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<tbody>
<tr>
<td>International Plan</td>
<td>Any Provider</td>
<td>CIGNA OAP (In-Network)</td>
</tr>
<tr>
<td>(paying non-U.S. premium rates)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit*</td>
<td>Per Individual</td>
<td>$1,000</td>
</tr>
<tr>
<td></td>
<td>Family Maximum</td>
<td>$2,000</td>
</tr>
<tr>
<td>Annual Maximum*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs—Inpatient</td>
<td>Covered as any other medical plan expense</td>
<td>See Prescription Drugs – U.S.</td>
</tr>
<tr>
<td>Drugs—Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision*</td>
<td>Annual Eye Exam</td>
<td>One vision exam reimbursed at 100% with no deductible per individual, per calendar year</td>
</tr>
<tr>
<td>Vision Materials</td>
<td></td>
<td>Annual maximum for vision materials (i.e. frames, glasses, lenses, etc.) is $300 with 80% co-insurance per individual, per calendar year</td>
</tr>
</tbody>
</table>

* Please refer to Glossary (for medical plan) section below for the definition of the table categories.

**U.S. Plan (for those paying U.S. rates)**
This section applies only to active employees and retired participants paying U.S. premium rates.

**For health care received in the U.S.,** the Plan pays a greater portion of your expenses if you use providers who are members of Cigna’s Open Access Plan (OAP) Network. Cigna’s OAP providers have agreed to discounted fees so by using them you will be paying a lower percentage of a lower charge. The OAP providers have direct-billing arrangements with Cigna, which facilitates the claims process. You can access Cigna OAP providers via the aiarc.org website.

**For health care received outside the U.S.,** the limit on your Out-of-Pocket expenses is lower. You can minimize your costs for health care received outside the U.S. by using providers in Cigna’s network of preferred providers. Cigna has negotiated attractive fees with these providers, so while the Plan pays 90% of most medical expenses outside of the U.S., your portion of costs will be lower by using providers in Cigna’s network. Network providers have direct-billing arrangements with Cigna which minimizes your paperwork. You can access Cigna’s preferred providers via the aiarc.org website.

**Medical Plan Care Summary Table (for those paying U.S. rates)**
The following table provides the basic medical plan design for active employees and retirees paying U.S. rates.

<table>
<thead>
<tr>
<th>Medical Care</th>
<th>Care Received in U.S.</th>
<th>Care Received Outside U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Plan (paying U.S. premium rates)</td>
<td>CIGNA OAP (In-Network)</td>
<td>CIGNA Non-OAP (Out-of-Network)</td>
</tr>
<tr>
<td>Annual Deductible*</td>
<td>Per Individual</td>
<td>$200</td>
</tr>
<tr>
<td></td>
<td>Family Maximum</td>
<td>$400</td>
</tr>
<tr>
<td>Hospital Deductible*</td>
<td>None</td>
<td>$500 per admission</td>
</tr>
<tr>
<td>(Applies to Medical Claims, except Preventive Care)</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Coinsurance (Plan Pays)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Out-of-Pocket Limit*</td>
<td>Per Individual</td>
<td>$2,500</td>
</tr>
<tr>
<td></td>
<td>Maximum per Family</td>
<td>$5,000</td>
</tr>
<tr>
<td>Annual Maximum*</td>
<td>No Coverage limit per individual, per calendar year</td>
<td>Covered as any other Medical Plan expense</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Medical Care</th>
<th>Care Received in U.S.</th>
<th>Care Received Outside U.S.</th>
<th>Any Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CIGNA OAP (In-Network)</td>
<td>CIGNA Non-OAP (Out-of-Network)</td>
<td></td>
</tr>
<tr>
<td>Drugs—Outpatient</td>
<td>See Prescription Drugs – U.S.</td>
<td>No Coverage</td>
<td>Covered as any other medical plan expense</td>
</tr>
<tr>
<td>Vision*</td>
<td>One vision exam reimbursed at 100% with no deductible per individual, per calendar year</td>
<td>Annual maximum for vision materials (i.e. frames, glasses, lenses, etc.) is $300 with 80% co-insurance per individual, per calendar year</td>
<td></td>
</tr>
</tbody>
</table>

*Please refer to Glossary (for Medical Plan) section below for the definition of the table categories.

### Glossary (for Medical Plan)

**Annual Deductible:** The annual deductible is the amount that you must pay and satisfy prior to receiving any coinsurance. The deductible applies per individual per calendar year. A family does not have to pay more than the Family Maximum in any calendar year. The deductible is waived for vision and dental coverage, for prescription drug coverage provided by Cigna in the U.S., and for preventive care exams and procedures. Deductible amounts you pay for care received in the U.S. will apply to your deductible for care received outside the U.S., and vice versa.

**Hospital Deductible:** Cigna’s network has many hospitals to choose from. You can find network hospitals from your personal account on the Cigna website. If you are admitted to a U.S. hospital that is not in Cigna’s OAP network, you must pay an additional $500 hospital deductible. This $500 does not count toward your deductible or out-of-pocket limit. Please refer to the Key Contact section in this summary to find OAP hospital providers in U.S.

**Coinsurance:** After you have satisfied your deductible, the Plan pays a percentage of covered expenses and you pay the remainder. The Plan pays a higher percentage of covered expenses if you use a Cigna network provider. You can access Cigna network providers, via the aiarc.org website.

**Annual Out-of-Pocket Limit:** The Plan limits how much you pay in out-of-pocket (OOP) covered expenses after the deductible in any calendar year. After the OOP Limit is reached, the Plan pays 100% of your covered expenses for the remainder of that calendar year. In addition, the Plan limits the OOP expenses for your family in a calendar year. Your OOP payments for care received in the U.S. count towards your OOP Limit for care received outside the U.S., and vice versa. For care received in the U.S., your OOP Limit is lower if you use Cigna OAP providers. The OOP Limit does not include what you pay for services and supplies that are not considered covered expenses by the Plan.

**Annual Maximum** The Plan does not have an annual maximum coverage limit per individual, per calendar year.

**Vision:** The Plan’s deductible does not apply to vision care expenses. The Plan will cover 100% of your costs for an annual vision exam. Vision materials (i.e. glasses, contacts and frames) are covered up to $300, with 80% co-insurance, per calendar year per individual. You must pay the costs first, and then submit a claim for reimbursement.
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### Tips for Avoiding Unnecessary Out-of-Pocket Expenses

**Hospital Admission Certification**

If you or a dependent require a non-emergency confinement in a hospital, hospice, skilled nursing facility, or convalescent care facility in the U.S., it is important that you receive certification from Cigna prior to the admission. **If you do not receive this certification, you will be charged an additional $400 per admission.** For hospital admissions outside of the U.S., certification is recommended but not required. Certification provides you and the provider with information about what the Plan will and will not pay in advance so there are no surprises when you receive the bill. The Cigna phone numbers needed to get certification are shown in the **Key Contacts** Section of this Summary.

**Emergency Room Admissions**

The Plan covers hospital emergency room expenses as long as there is a true emergency involved. However, the Plan will pay only 50% if the emergency room visit is considered to be a non-emergency. A non-emergency involves situations where the care could have been safely and adequately provided in a physician’s office or when using the emergency room was simply for the convenience of the patient.

**Using In-Network Health Care Providers**

If you are outside of the U.S., you can minimize your out-of-pocket medical and dental expenses by receiving care from Cigna’s in-network health care providers. To find these in-network health care providers, you will need to log in your personal account on the Cigna website. For information on creating a Cigna personal account, please visit [aiarc.org](http://aiarc.org).

If you are in the U.S., you can minimize your out-of-pocket expenses by receiving care from Cigna’s open access plus (OAP) providers for medical and preferred providers (PPO) for dental. Please refer to the Key Contact section in this summary to find the network providers in the U.S.
Prescription Drugs
All active, bridging, and retired participants are eligible for the prescription drug benefit. Your medical card will also serve as your drug card.

The following table provides the basic design of drug costs when purchasing at a retail pharmacy.

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Care Received Outside U.S.</th>
<th>Care Received in U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Category (Tier)</td>
<td>Any Provider</td>
<td>CIGNA OAP (In-Network)</td>
</tr>
<tr>
<td>Generic (Tier 1)*</td>
<td>90%</td>
<td>No copay</td>
</tr>
<tr>
<td>Preferred Brand (Tier 2)*</td>
<td>90%</td>
<td>$25/Rx copay</td>
</tr>
<tr>
<td>Non-Preferred Brand (Tier 3)*</td>
<td>90%</td>
<td>$80/Rx copay</td>
</tr>
</tbody>
</table>

* Please refer to Glossary (for Prescription Drug Plan) section below for the definition of the chart categories.

1 Generic is equivalent to brand name drugs that can be purchased at discount.
2 Brand name drugs that can be purchased at discount.
3 Brand name drugs that are not discounted by drug manufacturer.

For outpatient prescription drugs received outside the U.S. and inpatient drugs received anywhere, claims are reimbursed by Cigna and treated the same as any other Plan expense. You can submit your prescription drug claim electronically from your Cigna personal webpage account or by post mail. For information on submitting prescription drug claims to Cigna, please refer to the Submitting Your Claim Forms section of this Summary.

For outpatient prescription drugs received in the U.S., you must use a pharmacy in Cigna’s network of U.S. pharmacies. Otherwise you will be required to pay the full-retail price for the prescription and will not be able to submit the claim for reimbursement. Most national pharmacies are in Cigna’s network. You can access the network of pharmacies via the aiarc.org website.

Always present your Cigna ID card to the pharmacy when obtaining your prescription drugs in the United States. Your ID card contains important information, such as the RX issuer (80840), Rx Bin 017010, and RX PCN 02160000, that is required by a pharmacy to process your order. Please note that if you do not use your card at the time of purchase, you will only be reimbursed up to 50% of the retail price, when you submit your claim.

U.S. Retail Pharmacy
You are limited to a 30-day drug supply from the retail network pharmacy. For a 90-day supply, you will need to order prescription drugs from Cigna’s mail order service program. Please note that prescriptions cannot be mailed to an address outside the United States, and AIARC cannot act as the recipient of mail order drugs.

U.S. Mail Order
For a 90-day supply, you must request a mail order from the Cigna Tel-Drug Home Delivery Pharmacy Program in the United States. Please note that this home delivery program will not mail drugs to an address outside of the United States. You will need to enroll in the Cigna Tel-Drug program to order and refill prescription drugs. For instructions on enrolling in the Cigna Tel-Drug, please go to the aiarc.org website.
The following table provides the basic design of drug costs when orders are received by mail versus purchases made at a retail pharmacy.

<table>
<thead>
<tr>
<th>Prescription Drugs Costs in the U.S.</th>
<th>Mail Order — 90 Day Supply</th>
<th>Retail Pharmacy — 30 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Category (Tier)</td>
<td>CIGNA OAP (In-Network)</td>
<td>CIGNA OAP (In-Network)</td>
</tr>
<tr>
<td>Generic (Tier 1)*</td>
<td>Pays 100% after:*</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand (Tier 2)*</td>
<td>$50/Rx copay</td>
<td>$25/Rx copay</td>
</tr>
<tr>
<td>Non-Preferred Brand (Tier 3)*</td>
<td>$160/Rx copay</td>
<td>$80/Rx copay</td>
</tr>
</tbody>
</table>

* Please refer to Glossary (for Prescription Drug Plan) section below for the definition of the chart categories.

1. Generic is equivalent to brand name drugs that can be purchased at discount.
2. Brand name drugs that can be purchased at discount.
3. Brand name drugs that are not discounted by drug manufacturer.

Glossary for the Prescription Drug Plan, while in the U.S.

**Copay:** You will pay a copayment each time a prescription is filled, and the copay amount depends upon whether your physician prescribes a generic drug, a preferred brand drug, or a non-preferred brand drug. After you pay the applicable copay, Cigna will cover 100% of the drug costs. Your copays do not count toward the Plan’s Annual Deductible, Annual Maximum, Coinsurance, and Out-of-Pocket (OOP) Limits.

**Drug Category:** You can search for a specific drug and its tier category (i.e., generic, preferred, or non-preferred brand) using the Cigna’s drug formulary reference list web page mentioned in the Key Contacts section of this Summary. Please note that you will not be able to register at Cigna to view your plan information. You can only view your plan information at the Cigna website.
Dental

Only *active employees* and *bridging participants* are eligible for the dental benefit.

**For dental care received outside the U.S.**, you should always use providers that are in Cigna’s network outside the United States to minimize your out-of-pocket dental expenses and save time. You can access Cigna’s network of dentists via the [aiarc.org](http://aiarc.org) website.

**For dental care received in the U.S.**, you should always use providers that are in Cigna’s PPO network in the United States to minimize your out-of-pocket dental expenses and save time. You can access Cigna’s network of dentists in the United States via the [aiarc.org](http://aiarc.org) website.

### Dental Plan Care Summary Table (for those paying non-U.S. and U.S rates)

The following table provides a listing of the dental procedures that are covered and the respective co-insurance percentage.

<table>
<thead>
<tr>
<th>Dental Care</th>
<th>Care Received Outside U.S.</th>
<th>Care Received in U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Employee/Bridging</strong></td>
<td>Any Provider</td>
<td>CIGNA PPO (In-Network)</td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>$1,000 per individual, per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Care</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Preventative Care Limitations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>oral exams: 2 per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>cleanings: 2 per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>fluoride application: 1 per year – children only</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dental sealants on permanent molars: 1 every 3 years - children only</td>
<td></td>
</tr>
<tr>
<td></td>
<td>bitewings: 1 set per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>full mouth x-rays: 1 set every 3 years</td>
<td></td>
</tr>
<tr>
<td><strong>Basic Restorative Care</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Basic Restorative Care Limitations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>amalgam</td>
<td></td>
</tr>
<tr>
<td></td>
<td>silicate cement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>plastic &amp; composite restorations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>synthetic restorations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>oral surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>endodontics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>periodontics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>space maintainers</td>
<td></td>
</tr>
<tr>
<td><strong>Major Restorative Care</strong></td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Major Restorative Care Limitations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>inlays and crowns: replacement every 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>complete &amp; partial dentures: replacement every 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>dental implants, one-piece casting, including pontics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>bridges: replacement every 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>night guards for treatment of bruxism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>periodontal surgery</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment of Temporomandibular Joint Disorder</strong></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Cosmetic Dentistry</strong></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

*Please refer to *Glossary (for Dental Plan)* section below for the definition of the chart categories.*
# Glossary (for Dental Plan)

<table>
<thead>
<tr>
<th>Glossary Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Maximum:</strong></td>
<td>The maximum that the Plan will pay is up to $1,000 per calendar year for the dental expenses of each covered person.</td>
</tr>
<tr>
<td><strong>Deductible:</strong></td>
<td>The Plan’s deductible does not apply to dental care expenses.</td>
</tr>
<tr>
<td><strong>Care Limitations:</strong></td>
<td>There are limits on the number of dental services performed each year for each covered person unless your dentist submits a valid reason for more frequent services. In addition, your Plan is limited to pay a percentage of what Cigna determines to be the reasonable charge for each dental expense. The reasonable charge for a service or supply is the lower of the dentist’s usual charge for furnishing it, and the charge Cigna determines to be the prevailing charge level made for it in the geographic area where it is furnished. If your dentist bills for more than the reasonable charge, you are financially responsible for the excess charge. If you use a dentist in the Cigna PPO network, the total charge will never exceed the reasonable charge.</td>
</tr>
</tbody>
</table>
## What Your Plan Covers

The Plan will cover medical, prescription drug, and vision charges for:

<table>
<thead>
<tr>
<th>Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services of a physician legally qualified to provide those services.</td>
<td></td>
</tr>
<tr>
<td>Hospital room and board up to the average semi-private rate or the average private room rate if the hospital does not have semi-private rooms, plus other inpatient hospital services and supplies while hospitalized.</td>
<td></td>
</tr>
<tr>
<td>Convalescent care room and board up to 120 days per calendar year. Stay must come within 14 days of a hospital stay of at least 3 days. Care is not covered in a convalescent care facility resulting from drug or alcohol addiction, senility, mental retardation, chronic brain syndrome or other mental disorders.</td>
<td></td>
</tr>
<tr>
<td>Home health care agency services up to 120 days per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Outpatient hospital service and supplies.</td>
<td></td>
</tr>
<tr>
<td>Hospice care for up to 30 days of inpatient care and up to $5,000 for outpatient care.</td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests and x-rays.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care up to the equivalent of 70 eight-hour days per calendar year.</td>
<td></td>
</tr>
<tr>
<td>X-ray, radium and radioactive isotope therapy.</td>
<td></td>
</tr>
<tr>
<td>Physical and occupational therapy; however therapy, supplies or counseling is not covered when related to sexual dysfunctions.</td>
<td></td>
</tr>
<tr>
<td>Speech therapy to restore speech when it was lost due to a disease or injury.</td>
<td></td>
</tr>
<tr>
<td>Hearing aids will be covered up to a maximum of $2,500 per ear with a limit of one replacement every three calendar years. No deductible applies, but a 20% copayment from the participant is required.</td>
<td></td>
</tr>
<tr>
<td>Preventive exams (no deductible) including: one routine physical exam per adult and per child age 2 through 18; one women’s gynecological exam, pap smear and related lab work per calendar year; well-baby physical exams including immunizations—up to 6 exams in the 1st year and 2 in the 2nd year, with no annual maximum limit.</td>
<td></td>
</tr>
<tr>
<td>Maternity care and delivery.</td>
<td></td>
</tr>
<tr>
<td>Abortions only when there are medical complications or the mother’s life is in danger.</td>
<td></td>
</tr>
<tr>
<td>Outpatient in-vitro fertilization procedures up to 3 procedures per lifetime.</td>
<td></td>
</tr>
<tr>
<td>Mastectomies and the resultant breast reconstruction.</td>
<td></td>
</tr>
<tr>
<td>Professional ambulance services.</td>
<td></td>
</tr>
<tr>
<td>Treatment of mental disorders, alcoholism and substance abuse.</td>
<td></td>
</tr>
<tr>
<td>Chiropractic services up to $500 per individual per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Durable medical and surgical equipment rental.</td>
<td></td>
</tr>
<tr>
<td>Artificial limbs and eyes including their fitting.</td>
<td></td>
</tr>
<tr>
<td>Anesthetics and oxygen.</td>
<td></td>
</tr>
<tr>
<td>Drugs and medicines which by law require a physician’s prescription. Over-the-counter drugs, vitamins, and nutritional supplements are not covered.</td>
<td></td>
</tr>
<tr>
<td>Preventive vaccinations with no deductible include: DI-TE-PER vaccinations for diphtheria, tetanus and whooping cough; combined vaccinations for measles, mumps and rubella; pneumococcal vaccinations for children and adults age 65+ (subject to pre-approval); HPV vaccinations; hepatitis A and B vaccinations; influenza vaccinations; meningococcal vaccinations; polio (IPV) vaccinations; rotavirus vaccinations; preventive treatment for malaria; haemophilus influenza type B vaccinations; vaccinations for shingles.</td>
<td></td>
</tr>
<tr>
<td>Self-injectable drugs for insulin, epi-pens and heparin. Other self-injectable drugs must be pre-authorized by Cigna.</td>
<td></td>
</tr>
</tbody>
</table>
Dental care (in lieu of the dental coverage described above) when treatment is the result of a disease or accidental injury.

Acupuncture, only when performed by a licensed physician for the purpose of anesthesia in connection with surgery that is covered by the Plan.

### What Your Plan Does Not Cover

**The Plan will not cover the following medical, prescription drug, and vision charges:**

- Made by a provider of health care services or supplies that are above what is considered reasonable based on the location of care and the nature of the service or supply.
- Not prescribed, recommended and approved by your physician or dentist.
- Primarily for custodial care.
- Related to sex change surgery or treatment of gender identity disorders.
- For the following types of counseling: marriage, family, child, career, social adjustment, pastoral, and financial.
- For acupuncture (unless performed by a licensed physician for purposes of anesthesia, see above) or acupressure.
- For services not necessary to treat the medical or dental condition.
- For services considered experimental or investigational.
- For services related to learning disabilities or developmental delays.
- Already covered by another governmental (including Medicare), armed forces, union, or employer plan.
- For services related to primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetics therapy, vision perception training or carbon dioxide therapy.
- For a sterilization procedure or its reversal.
- To improve, alter or enhance appearance (with certain exceptions after a mastectomy and repair of an injury occurring while covered under the Plan).
- Vision training, non-prescription glasses, and laser eye surgery or vision correction (LASIK).
Submitting Your Claim Forms

All qualifying claims (medical, vision, dental and prescription drugs) should be submitted as soon as possible. To expedite and ensure payment, a claim should be submitted within 90 days after the date of service. Please note that no payment will be made for any claim submitted later than one year after the date of service.

You can submit claims electronically or by postal mail. By submitting claims electronically, you will avoid postal delays and costs. For treatment in the United States, providers will often bill Cigna directly and then send you an invoice for your share of the costs.

To expedite the payment of your claim, please make sure that your claim has the following information:

- Plan Member and Patient Information
- Date of Service
- Description of each Service received
- Currency of the Claim
- Exact amount of Expenses
- Additional Diagnosis (Note: this section is very important to have completed)
- Bank details for payment by transfer

Electronic Claims via Cigna Personal Webpage

To submit claims electronically, arrange direct-deposit payments, find in-network health care providers, and print medical ID cards, you will need to create a personal account on the Cigna website

For more information about the online claims process, please refer to AIARC’s website (Choose “Medical | Plan Overview” from the menu and “Claim Procedure” from the subheadings on that page.)

After you submit your claim online, you will receive an email to confirm your submission. It is recommended that you keep the original invoices and supporting documentation for a period of at least six months after the electronic submission of your claim. Once your claim has been processed, you will be notified by email and your settlement details will be available online.

Please remember to scan all invoices and other supporting documents in advance so you can attach them to your claim within the Cigna website.

Submitting Claims by Mail

To submit claims by mail, you will need to download the claim form from the Cigna website and send the completed claim form with original invoices and with proof of the nature and extent of the treatment. This form is customized for your personal use: your name and your personal reference number (transcribed into a corresponding barcode) are automatically filled in on the downloadable form. Send the claim form along with documentation for the claim to the address listed in the Key Contacts section. Please make copies of all your documents for your personal records before mailing.

Claims for Vaccinations Given at the Pharmacy

In the U.S., many pharmacies provide basic services for the vaccinations listed in the section What Your Plan Covers, e.g. for influenza, shingles and pneumonia among others. The IARC Medical Plan covers these vaccinations at the pharmacies.
2017 IARC Medical Plan Benefit Summary

Always present your Cigna card to the pharmacist before receiving any vaccination (as well as medication). Remember that within the United States of America, failure to present your insurance card to the pharmacy means that Cigna will consider that pharmacy’s drugs and vaccinations as out of network. When submitting a claim for a vaccination, the name of the vaccination must be listed on or with the receipt to claim for reimbursement. Otherwise, the claim will not be reimbursed.

**Guarantee of Payment**

*To prevent you from having to pay for the total cost of your medical treatment in advance, it is recommended that you request a Guarantee of Payment from Cigna.*

A Guarantee of Payment states whether or not the required treatment is covered and what portion of the expense is covered by Cigna. You will pay your portion of the required deductible and co-insurance to the healthcare provider, and Cigna will pay its portion of the costs directly to the healthcare provider.

To expedite the Guarantee of Payment, have your healthcare provider complete the Cost Estimate Form from the Cigna website and send the completed Cost Estimate Form to Cigna at authorization@cigna.com at least two weeks prior to the date of the scheduled treatment.

*It is also recommended that you use Cigna in-network providers for planned or emergency hospital admissions because a Guarantee of Payment will be easier and faster to obtain than for out-of-network providers. For out-of-network providers, you may have to pay the provider in advance and submit the full claim to Cigna for reimbursement.*

**Coordination of Claims with Other Plans**

In the event a person covered by the IARC Medical Plan is also covered by another similar plan (e.g., the medical plan provided by a spouse’s employer), the IARC Plan will consider that:

- the plan that covers the employee is always primary to the plan that covers the employee as a dependent, and
- the primary plan for a dependent that is covered by both parents’ plans will be the plan of the parent whose birth month/day is earlier in the year.
Key Contacts
You can access all of the various insurance provider information from the AIARC website. However, to access specific provider information, you will need to create a personal account with a password to manage your various benefits. It is recommended that you establish your account before you actually need to use it. It is also recommended that you enter the contact information and your account passwords into your mobile phone for quick access in case of an emergency.

### AIARC
- **Website**: [www.aiarc.org](http://www.aiarc.org)
- **U.S. Phone**: 1–703–548–4540
- **U.S. Fax**: 1–703–548–5960
- **Address**: 901 North Washington Street, Suite 706, Alexandria, VA 22314, USA

### Cigna (Medical, Vision and Dental)
- **Website**
  - [www.cignahealthbenefits.com](http://www.cignahealthbenefits.com) (to find in-network providers outside of U.S.)
  - [cigna.benefitnation.net](http://cigna.benefitnation.net) (to find in-network providers in the U.S.)
- **Phone**
  - +32–3–217–6947 (Antwerp, Belgium) — 24/7 Contact Center
  - +1–866–253–3003 (Miami, US) — 24/7 Contact Center
  - +32–3–293–18–11 (Europe, Africa & Middle East)
  - +1–305–908–92–11 (North & South America)
  - +603–217–814–11 (Asia & Pacific)
  - +603–2178–0502 (Malaysia local)
  - +254–722–86–91–06 (Kenya local)
- **Fax**
- **Email**:
  - [aiarc@cigna.com](mailto:aiarc@cigna.com) (for all inquiries)
  - [authorization@cigna.com](mailto:authorization@cigna.com) (request for guarantee of payments)
  - [bills@cigna.com](mailto:bills@cigna.com) (billing inquiries)
  - [mcck@cigna.com](mailto:mcck@cigna.com) (Malaysia local)
  - [kenya@cigna.com](mailto:kenya@cigna.com) (Kenya local)

### Cigna (U.S. Prescription Drugs)
- **U.S. Retail Pharmacy**
  - Rx Bin# 017010, Rx Issuer (80840), Rx PCN 02160000 (required for 30-day supply)
- **U.S. Mail Order**
  - [www.teldrug.com](http://www.teldrug.com) (for 90-day supply)
- **Phone**
  - 1–800–TEL–DRUG or 1–800–835–3784 (for drug order)
  - 1-800-622-5579 (for drug override or correction of patient’s information)

### Cigna Claims
- **For electronic claims (website)**: [www.cignahealthbenefits.com](http://www.cignahealthbenefits.com)
- **For post mail claims (mailing address)**
  - Cigna, P.O. Box 69, 2140 Antwerpen, BELGIUM (non-courier mail)
  - Cigna, Plantin en Moretuslei 299,2140 Antwerpen, BELGIUM (courier)
  - Cigna, P.O. Box 260790, Miami, FL 33126, USA
  - Cigna, 3B-15-3A, Block 3B, Plaza Sentral, Jalan Stesen Sentral 5, 50470 Kuala Lumpur, MALAYSIA