IARC Medical Plan Benefits Summary

Effective 1 January 2024

AIARC

Association of International Agricultural Research Centers

Information contained in this summary does not imply or form a contractual arrangement. The summary is only intended to provide an IARC Insurance Plan participant with jargon-free general information about the IARC Medical Plan sponsored by the IARC Retirement Plant Trustee Limited 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 the IARC Retirement Plan Trustee and the plan providers, which constitute the legal documents that govern the operation of the IARC Medical Plan. The IARC Medical Plan's 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 the IARC Retirement Plan Trustee Limited.

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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 employment classifications and retired participants from Centers who are members of the Association of International Agricultural Research Centers (AIARC), a nonprofit organization located in Alexandria, Virginia, U.S.A. The Plan covers expenses for a range of health-care services and supplies including medical, vision, prescription drugs, and dental care. For the most up-to-date information about benefits, please refer to the aiarc.org website.

Roles of the IARC Plan Trustee, AIARC and Plan Partners

To provide insurance and retirement benefits to the various employment classification of Centers, the IARC Retirement Plan Trustee, Ltd. (the Trustee) was formed in and operates from Guernsey, Channel Islands. The Trustee contracts with AIARC to provide the day-to-day administration of the Plan to include financial accounting and recordkeeping, resolution of claim issues, vendor management, legal research, participant communication, and vendor bids. AIARC's activities are monitored by a Board of Directors primarily composed of representatives from member Centers.

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

- Cigna International, based in Antwerp, Belgium, is responsible for administering medical, dental, and prescription-drug claims for the Plan's participants.
- Cigna International partners with Cigna Healthcare 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 the provider network and claims service for outpatient prescription drugs received in the U.S.

Eligibility, Enrollment, and Termination

Employment Classifications for "Active Employees"

Eligibility

You are eligible for coverage if your Center sponsors the Plan and if you are enrolled as an "active employee" by your Center because you meet the respective criteria for one of the following employment classifications. *Please note that only the employment classifications for full-time and part-time employees are eligible for Bridging or Retired coverage. All other employment classifications are not eligible to continue medical insurance after terminating employment from the Center. For questions about your employment classification, please contact your Center's human resources department.*

- A full-time employee working your Center's normal work week;
- A part-time employee working at least 20 hours per week or 50% of your Center's normal work week and hired to work at the Center for at least one year;
- A long-term consultant contracted to work for a Center for at least a year;
- A short-term employee or consultant contracted to work for a Center less than a year but more than two months;*
- 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;* or
- A very short-term employee working at a Center for less than two months.*

**Please note that participants who are enrolled as short-term or very short-term employees, short-term consultants, visiting scientists, and trainees/students are not eligible for dental and vision benefits.*

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Enrollment and Effective Date

Upon your hire, your Center will provide you with an IARC Insurance Plan Enrollment Form for you to enroll yourself and eligible dependents. Once you are enrolled in the IARC Medical insurance Plan, Cigna will send an email notification to your email address that is listed on your IARC Insurance Enrollment Form. Cigna's email notification will include your insurance reference number starting with (217) and instructions on how to activate/register your Cigna Personal Webpage at https://www.cignahealthbenefits.com/.

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. 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. Refer to the *Pre-existing Condition Limitation* section of this brochure. However, you can postpone enrollment without penalty if you have existing coverage under another medical plan at the time of your normal effective date. If you wish to decline coverage, 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, part-time employee, or long-term consultant, Plan benefits for you and your eligible dependents will cease 25 days following the day you terminate employment from your Center. If you are enrolled in another employment classification, coverage ceases on the day that you terminate employment from your Center.

Bridging and Retired Participants

Eligibility for Bridging Coverage

To qualify for bridging insurance, you must have been enrolled in the employment classification of full-time or part-time employee in the IARC Medical Plan for at least the two most recent consecutive years (24 months) immediately prior to termination.

Please note that only your time enrolled in the Plan in the employment classification of full-time or part-time employee will count in the calculation of the minimum length of employment requirement to be eligible for bridging coverage. Your time enrolled in other employment classifications will not count in the calculation of the minimum length of employment requirement to be eligible for bridging coverage.

The full-time or part-time employee must have worked at least 20 days per month to have an entire month counted towards the length of employment requirement of 24 months to be eligible for bridging insurance. The full-time or part-time employee, who has worked less than 20 days in a month but has worked at least 10 days in the same month, will have a half-month counted towards the length of service requirement. The full-time or part-time employee who has worked less than 10 days in a month will have zero time counted towards the length of service requirement.

Eligibility for Retiree Coverage

To qualify for retiree insurance, you must be at least 60 years old and have been enrolled in the employment classification of full-time or part-time employee in the IARC Medical Plan for at least 10 years (120 months) including the five consecutive years (60 months) immediately prior to your

retirement. *Please note that if your employment start date was prior to 01 January 2022, you will remain eligible for retiree coverage at age 55.*

Please note that only your time enrolled in the Plan in the employment classification of full-time or part-time employee will count in the calculation of the minimum length of employment requirement to be eligible for Retiree coverage. Your time enrolled in other employment classifications or bridging insurance will not count in the calculation of the minimum length of employment requirement to be eligible for Retiree coverage.

The full-time or part-time employee must have worked at least 20 days in a month to have an entire month counted towards the length of employment requirement of 120 months to be eligible for retiree insurance. The full-time or part-time employee, who has worked less than 20 days in a month but has worked at least 10 days in the same month, will have a half-month counted towards the length of employment requirement. The full-time or part-time employee who has worked less than 10 days in a month will have zero time counted towards the length of employment requirement.

If you qualify for both bridging and retiree insurance, you can only choose one option upon your separation. Please further note that 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 directly from the Centers.

Retired Participants (65 years of age or older) residing in U.S.

Retired participants, who reside in the United States and who are 65 years of age or older, must enroll in Medicare Parts A and B if they are eligible. To find out if you are eligible for Medicare, contact your local Social Security office at 1-800-772-1213 within the United States or visit the Medicare website at www.medicare.gov.

To receive the premium discount, you must send AIARC a copy of your Medicare eligibility letter from the Social Security office or a copy of your Medicare card for parts A and B. Your medical premium will be discounted only after a copy of the Medicare letter or card has been received by AIARC, and you will only receive the discount going forward after the proof of Medicare information 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 for Bridging and Retiree Insurance

AIARC will provide you with an IARC Insurance Plan Change Form and a new Tax Residency Declaration 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 with your Center. Your bridging or retiree insurance will begin on the first day after the 25-day grace period. Your existing Cigna membership card will not change.

Important: If you fail to submit a completed IARC Insurance Plan Change Form and a new Tax Residency Declaration Form within 25 days after your last day of coverage in the employment classification of full-time or part-time employee, you will lose the right to participate in the bridging or retiree insurance. You will not be able 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 do 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 12 months (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 to 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 a participant cannot 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 continue coverage by paying the required premium, until they are no longer eligible.

Eligibility for Domestic Partnerships

The Trustee's 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 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 for Dependents

If you are covered by the Plan and have 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 your partner's 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 for Dependents

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 eligible 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 reduced 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 a new participant was 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 eligible 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.

Your Cigna Electronic Membership Card

Once you are enrolled in the Plan, you and your eligible dependents will be able to access a Cigna electronic membership card that includes the Cigna reference / ID number, Account (Group) number, Prescription drug RX details when in the United States, Cigna 24/7 phone numbers and email addresses to make general inquiries, request guarantees of payment, and assist with filing medical claims.

You can print or download a copy of your Cigna electronic membership card from your Cigna Personal Webpage Account, which is described in the next section.

Use your Cigna Personal Webpage to manage your benefits

To manage your IARC Medical Plan benefits, you, will need to activate your Cigna Personal Webpage Account. To set up your account, refer to the Cigna Personal Webpage Instructions on the AIARC.org website. By logging into your Cigna Personal Webpage, you will be able to:

- print membership cards,
- print proof of insurance certificates,
- search for Cigna in-network providers available outside of U.S.,
- submit, check, and review claims,
- review individual and family benefits limits, and
- request for Guarantee of Payment (GOP).

You can also manage your account from your smartphone by downloading the Cigna **Health Benefits App** from the Apple App Store℠ or Google Play™ for Android. For guidance on downloading the app, refer to the Cigna Benefits App Manual.

Note: To access your Cigna account from the Health Benefits App, you will need to first activate and set up the login credentials for your Cigna Personal Webpage account.

How Your Plan Works

Medical

Your medical plan design is based on whether you or your Center on your behalf is paying the U.S. premium rate, International–Europe premium rate, or International–Other premium rate. Specifically, if you or your Center is paying the U.S. premium rate, you will be enrolled in the U.S. Plan, if you or your Center is paying the International–Europe premium rate, you will be enrolled in the International–Europe Category, and if you or your Center is paying the International–Other premium rate you will be enrolled in the International–Other Category.

Glossary for the Medical Plan

The following are key words with respective definitions to assist you in understanding how the medical plan works.

Annual Deductible:	The annual deductible is the amount that you must pay before Cigna makes any coinsurance payment. 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, dental, outpatient prescription drugs, preventive care, vaccinations recommended by the World Health Organizations, and hearing aids. There is no deductible required for using Cigna's Online Telehealth Service or International Employee Assistance Program (IEAP). 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: **(Only applies to hospitals in the U.S.)**	Cigna's Open Access Plan (OAP) has many hospitals in the U.S. to choose from. You can find network hospitals in the U.S. 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 hospital deductible does not count toward your Plan's annual deductible or out-of-pocket limit. You can look up Cigna network providers in your Cigna Personal Webpage account.
Coinsurance:	After you have satisfied your annual deductible, the Plan pays a percentage of covered expenses, and you pay the remainder. In the U.S., the Plan pays a higher percentage of covered expenses if you use a Cigna network provider. You can look up Cigna network providers in your Cigna Personal Webpage account.

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.

International Plan (International–Europe Category and International–Other Category)

Note: This section applies only to active and retired participants paying an international premium rate (non-U.S. premium rate).

For care received outside the U.S., the Plan generally pays 90% of your expenses after you satisfy the Annual Deductible. *Please note that there is no Annual Deductible for Active Employees enrolled in the International–Other Category when receiving care outside of the U.S. and Europe.* You can minimize your costs by using a provider in Cigna's network of preferred providers. Cigna has negotiated discounted 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 often have direct-billing arrangements with Cigna, which minimizes your paperwork. You can look up the Cigna network providers in your Cigna Personal Webpage account. For information on creating a Cigna personal account, please refer to Cigna Personal Webpage instructions on 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 find Cigna OAP providers in Cigna's U.S directory.

International Plan Summary Table (for those paying a non-U.S. premium rate)

The following table provides the basic medical plan design for active and retired participants paying an international rate (a non-U.S. premium rate). Please refer to the section "What your Plan Covers" for more details about your plan benefits.

****Please note that there is no Annual Deductible for Active Employees enrolled in the International–Other Category while receiving care outside the U.S. and Europe***

Medical Care	Care Received Outside U.S.	Care Received in the U.S.	
		Cigna OAP (In-Network)	Cigna Non-OAP (Non-Network)
Annual Deductible Per Individual Family Maximum	 $200* $400*	 $300 $600	 $500 $1,000
Hospital Deductible	None	None	$500 per admission

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Medical Care	Care Received Outside U.S.	Care Received in the U.S.	
		Cigna OAP (In-Network)	Cigna Non-OAP (Non-Network)
Coinsurance (Plan Pays)	90%	80%	60%
Annual Out-of-Pocket Limit Per Individual Family Maximum	 $1,000 $2,000	 $3,000 $6,000	 $6,000 $12,000
Annual Maximum	No limit on annual claims payments		
Special Plan Features Preventive Medical Care	Deductible waived & 100% coinsurance for: • Annual routine adult physical exam • Annual women's gynecological exams, including pap smear & related lab work • Annual routine child physical exam ages 2 through 18 • Well-baby exams & immunizations – up to 6 exams in 1st year & 2 exams in 2nd year • Preventive vaccinations (refer to What your Plan Covers section for vaccinations covered)		
Vision	Deductible waived: • 100% coinsurance for annual vision exams • 80% coinsurance for materials (lenses, frames, contacts) up to $300 per calendar year		
Hearing Aids	Deductible waived: • 80% coinsurance • Limited to $2,500 per ear & 1 replacement every 3 calendar years		
Employee Assistance Plan	Deductible waived & 100% coinsurance for 24/7/365 telephone, video & email access to professional counselling for family, work & other personal issues (refer to IEAP and Telehealth Service section)		
Prescription Drugs	Deductible waived: (refer to Prescription Drugs section for the benefit description for purchases outside of and in the U.S.)		
Dental	Deductible waived: (refer to Dental section for a benefit description)		

U.S. Plan

Note: This section applies only to active and retired participants paying a U.S. premium rate.

For 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 find Cigna OAP providers in Cigna's U.S directory.

For 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 discounted 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 often have direct-billing arrangements with Cigna which minimizes your paperwork. You can find Cigna's preferred providers in your Cigna Personal Webpage

account. For information on creating a Cigna personal account, please refer to Cigna Personal Webpage instructions on the aiarc.org website.

U.S. Plan Care Summary Table (for those paying a U.S. premium rate)

The following table provides the basic medical plan design for active and retired participants paying a U.S. premium rate. Please refer to the section "What your Plan Covers" for more details about your plan benefits.

Medical Care	Care Received in the U.S.		Care Received Outside the U.S.
	Cigna OAP (In-Network)	Cigna Non-OAP (Non-Network)	
Annual Deductible Per Individual Family Maximum	 $200 $400	 $400 $800	 $200 $400
Hospital Deductible	None	$500 per admission	None
Coinsurance (Plan Pays)	90%	70%	90%
Annual Out-of-Pocket Limit Per Individual Family Maximum	 $2,500 $5,000	 $5,000 $10,000	 $1,000 $2,000
Annual Maximum	No limit on annual claims payments		
Special Plan Features Preventive Medical Care	Deductible waived & 100% coinsurance for: • Annual routine adult physical exam • Annual women's gynecological exams, including pap smear & related lab work • Annual routine child physical exam ages 2 through 18 • Well-baby exams & immunizations – up to 6 exams in 1st year & 2 exams in 2nd year Preventive vaccinations (refer to What Your Plan Covers section for vaccinations covered)		
Vision	Deductible waived: • 100% coverage for annual vision exams 80% coverage for materials (lenses, frames, contacts) up to $300 per calendar year		
Hearing Aids	Deductible waived: • 80% coinsurance Limited to $2,500 per ear & 1 replacement every 3 calendar years		
Employee Assistance Plan	Deductible waived & 100% coinsurance for 24/7/365 telephone, video & email access to professional counselling for family, work & other personal issues (refer to IEAP and Telehealth Service section)		
Prescription Drugs	Deductible waived: (refer to Prescription Drugs section for the benefit description for purchases inside and outside of the U.S.)		
Dental	Deductible waived: (refer to Dental section for a benefit description)		

Tips for Avoiding Unnecessary Out-of-Pocket Expenses

Hospital Admission Certification	If you or a dependent requires 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 $500 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 for 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 Cigna Personal Webpage account. For information on creating a Cigna personal account, please refer to Cigna Personal Webpage instructions on the 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.

Request a Guarantee of Payment to prevent unexpected medical costs

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 (GOP) from Cigna.

A Guarantee of Payment (GOP) 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. *Please note that Cigna will only issue a Guarantee of Payment for medical care expenses over USD 400. However, for medical expenses between USD 200 to USD 400, Cigna can issue a Verification of Benefits to the healthcare provider to confirm that Cigna will make the payment for the treatment.*

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. Please include your Cigna Personal Reference Number when you submit your GOP request to Cigna. The more time that Cigna has to negotiate the Guarantee of Payment with the healthcare provider, the better the chance that your estimated cost will be lower.

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

For information on requesting a guarantee of payment, refer to instructions on the AIARC website.

Use Cigna online Telehealth Service to save time and money

(Can be accessed via the Cigna Wellbeing App)

Cigna's online Telehealth Service will provide you with access to schedule a same-day consultation with doctors around the world by phone or video for non-emergency health issues and prescriptions. The primary advantages of this service are:

- not having to leave your home for non-urgent care or prescriptions,
- having access to over 110 board-certified doctors around the clock (24/7/365), specializing in internal medicine, gastroenterology, orthopedic, mental health, pediatrics, etc., and
- having zero out-of-pocket costs because deductibles or coinsurance payments do not apply when utilizing Telehealth.

To use the Cigna Telehealth service, you will need to download the **Cigna Wellbeing App** to your smart devices from the Apple App Store℠ or Google Play™ for Android. To learn more about Telehealth, refer to the Cigna Global Telehealth Brochure.

International Employee Assistance Program (IEAP)

The IARC Plan offers an International Employee Assistance Program (IEAP) for you or your dependents to talk to licensed counselors around the world and receive professional counselling, resources, referrals, and information related to issues such as balancing personal and work life, family, mental health, stress and cultural adaptation, etc.

You can access the IEAP services by phone, email, or via the Cigna Wellbeing App from your smart devices.

Prescription Drugs

All active, bridging, and retired participants are eligible for the prescription drug benefit. Your Cigna electronic membership card will also serve as your prescription drug card.

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

Prescription Drugs Retail — 30 Day Supply	**Care Received Outside U.S.**	**Care Received in U.S.**	
Drug Category (Tier)	**Any Provider**	**CIGNA OAP (In-Network)**	**CIGNA Non-OAP (Out-of-Network)**
Generic (Tier 1)	Reimbursed at 90% with no deductible.	Pays 100% after: No copay	Reimbursed up to 50% of retail price.
Preferred Brand (Tier 2)		$25/Rx copay	
Non-Preferred Brand (Tier 3)		$80/Rx copay	

Please refer to the **Glossary** to find what the key terms for the Prescription Drug Plan mean.

Tier 1: Generic drugs are the chemical equivalents to brand name drugs but are produced at a lower cost. Not all brand name drugs have generic equivalents.
Tier 2: Brand name drugs are those non-generic drugs for which Cigna has negotiated a cost discount from the drug manufacturer.
Tier 3: Brand name drugs are those non-generic drugs for which Cigna has not negotiated a discount. Using a lower number tier drug will save you money.

For prescription drugs received outside the U.S., claims are reimbursed by Cigna and treated the same as any other Plan expense, except that the annual deductible does not apply to the purchase of outpatient drugs. You can submit your prescription drug claim electronically from your Cigna personal webpage account or from your mobile phone using the Cigna Health Benefits App . For information on submitting prescription drug claims to Cigna, please refer to the Submitting Your Claim Forms section of this Summary.

U.S. Retail Pharmacy

For outpatient prescription drugs received in the U.S., you must use a pharmacy in Cigna's network of U.S. pharmacies. Otherwise, if you use an out-of-network pharmacy, you will be required to pay the full-retail price for the prescription, then submit for reimbursement at which you will only be reimbursed up to 50% of the retail price. Most national pharmacies are in Cigna's network. You can look up the network of pharmacies using the Cigna Pharmacy Directory.

Always present your Cigna electronic or printed membership card to the pharmacy when obtaining your prescription drugs in the United States. Your electronic membership card contains important information, such as the **RXGRP NRBA, RX issuer (80840), Rx Bin 017010, and RX PCN 0216INTL** that is required by a pharmacy to process your order. *You can print or download the Cigna electronic membership card for you and your dependents from your Cigna Personal Webpage Account.* To learn how to activate your account, refer to the AIARC.org website. 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.

You are limited to a 30-day drug supply from the retail network pharmacy**.** If you need a 90-day supply, it is recommended that you order prescription drugs from Cigna's mail order service program, which should save you money.

For vaccinations received at a pharmacy, the same policies, and procedures for receiving outpatient prescription drugs in the U.S. will apply. To learn about preventative vaccinations that are covered at 100%, with no deductible, refer to the vaccination list in the **What Your Plan Covers** section.

U.S. Mail Order (Cigna Home Delivery Pharmacy)

You are able to refill up to a 90-day supply of your prescription drug using **Cigna Home Delivery Pharmacy - Express Scripts** in the United States. For instructions on registering your account with Express Scripts so that you can order new prescriptions and refills, and track your orders online, please visit aiarc.org/Prescription-Drugs on the aiarc.org website.

Please note that Cigna's mail order prescription drugs cannot be mailed to an address outside the United States, and AIARC cannot act as the recipient of mail order drugs on behalf of plan participants.

The following table provides a general comparison of prescription drug costs when orders are received by mail versus purchases made at a retail pharmacy.

Prescription Drugs Costs in the U.S.	**Mail Order 90 Day Supply**	**Retail Pharmacy — 30 Day Supply**	
Drug Category (Tier)	**CIGNA OAP (In-Network)**	**CIGNA OAP (In-Network)**	**CIGNA Non-OAP (Out-of-Network)**
Generic (Tier 1)	Pays 100% after: No copay	Pays 100% after: No copay	Reimbursed up to 50% of retail price
Preferred Brand (Tier 2)	$50/Rx copay	$25/Rx copay	
Non-Preferred Brand (Tier 3)	$160/Rx copay	$80/Rx copay	

Please refer to the **Glossary** to find what the key terms for the Prescription Drug Plan mean.

Tier 1: Generic drugs are the chemical equivalents to brand name drugs but are produced at a lower cost. Not all brand name drugs have generic equivalents.
Tier 2: Brand name drugs are those non-generic drugs for which Cigna has negotiated a cost discount from the drug manufacturer.
Tier 3: Brand name drugs are those non-generic drugs for which Cigna has not negotiated discounts. Using a tier-one or tier-two drug will save you money.

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, Coinsurance, and Out-of-Pocket (OOP) Limits.
Drug Lists and Coverage:	You can search for a specific drug and its tier category (i.e., generic, preferred, or non-preferred brand) by using Cigna's U.S. drug formulary reference list. To search for a drug covered in the IARC Plan, select "Look Up Drug Lists for Employer Plans", choose Legacy 3 Tier from the drug list drop-down menu, then enter the drug name to find if it is available.

Dental

Please note that participants who are enrolled as short-term or very short-term employees, short-term consultants, and trainees/students are not eligible for the dental benefits.

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 look up Cigna's network of dentists from your Cigna Personal Webpage account.

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 look up Cigna's network of dentists in the United States using the Cigna Global Health Benefits Dental Directory.

Dental Plan Care Summary Table

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

Dental Care	Care Received Outside U.S.	Care Received in U.S.	
Benefit	**Any Provider**	**CIGNA PPO (In-Network)**	**CIGNA Non-PPO (Out-of-Network)**
Annual Maximum	$2,000 per individual, per calendar year		
Deductible	None		
Preventative Care	100%	100%	90%
Preventative Care Limitations	• oral exams: 2 per year • cleanings: 2 per year • fluoride application: 1 per year – children only • dental sealants on permanent molars: 1 every 3 years – children only • bitewings: 1 set per year • full mouth x-rays: 1 set every 3 years		
Basic Restorative Care	80%	80%	70%
Basic Restorative Care Limitations	• amalgam • silicate cement • plastic & composite restorations • synthetic restorations • oral surgery • endodontics • periodontics • space maintainers		
Major Restorative Care	60%	60%	50%

2024 IARC Medical Plan Benefit Summary

Dental Care	Care Received Outside U.S.	Care Received in U.S.	
Benefit	**Any Provider**	**CIGNA PPO (In-Network)**	**CIGNA Non-PPO (Out-of-Network)**
Major Restorative Care Limitations	• inlays and crowns: replacement every 5 years • complete & partial dentures: replacement every 5 years • dental implants, one-piece casting, including pontics • bridges: replacement every 5 years • night guards for treatment of bruxism • periodontal surgery		
Orthodontics	Covered at 50% of expenses up to lifetime maximum of $1,500 up to age 18.		
Cosmetic Dentistry	Not covered		
Treatment of Temporomandibular Joint Disorder	Not covered		

Glossary for the Dental Plan

Annual Maximum:	The maximum that the Plan will pay is up to $2,000 per calendar year for the dental expenses of each covered person.
Deductible:	There is no deductible for dental care expenses.
Care Limitations:	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 the service or supply, and the charge Cigna determines to be the prevailing charge level in the geographic area where service or supply 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.

What Your Plan Covers

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

Preventative Vaccinations: The following preventive vaccinations are covered at 100%, with no deductible:

- Cholera vaccinations
- Combination vaccinations that prevent measles, mumps, and rubella
- Covid-19 vaccinations (note: Covid-19 testing is only covered when prescribed by a doctor)
- DI-TE-PER vaccinations that prevent diphtheria, tetanus, and pertussis (whooping cough).
- Haemophilus influenza type B (Hib) vaccinations that prevent meningitis, pneumonia, and epiglottitis
- Hepatitis A, Hepatitis B, and Hepatitis E vaccinations
- HPV vaccinations that prevent infection by human papillomavirus which leads to cervical, anal, vaginal and mouth cancer.
- Influenza vaccinations (seasonal flu shots)
- Japanese encephalitis vaccinations
- Malaria prophylaxis vaccinations
- Meningococcal disease vaccinations that prevent types A, C, W-135, and Y
- Pneumococcal vaccinations that prevent pneumonia, meningitis, and sepsis.
- Polio vaccinations given as an injection (IPV) or orally (OPV)
- Rabies vaccinations
- Rotavirus vaccinations that prevent severe diarrhea
- Tick-borne encephalitis vaccinations
- Typhoid fever vaccinations
- Varicella vaccinations that prevent chicken pox.
- Yellow fever vaccinations

Annual vision exams are covered at 100% and frames and prescription lenses (including contact lenses) are covered at 80% up to $300 per individual per calendar year.

Hearing aids are 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.

Drugs and medicines which by law require a physician’s prescription. Over-the-counter drugs, vitamins, and nutritional supplements are not covered.

Dental care (in lieu of the dental coverage described above) when treatment is the result of a disease or accidental injury.

Services of a physician legally qualified to provide those services.

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, and other medically necessary hospital services, supplies, and medications received while hospitalized.

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, intellectual disabilities, chronic brain syndrome, or other mental disorders.

Home health care agency services up to 120 days per calendar year.

Outpatient hospital service and supplies.

Hospice care for up to 30 days of inpatient care and up to $5,000 for outpatient care.

Diagnostic tests and x-rays.

Skilled nursing care up to the equivalent of 70 eight-hour days per calendar year.

X-ray, radium, and radioactive isotope therapy.

Physical and occupational therapy; however, therapy, supplies and counseling are not covered when related to sexual dysfunctions.
Speech therapy to restore speech when it was lost due to a disease or injury.
Maternity care and delivery.
Outpatient in-vitro fertilization procedures up to 3 procedures per lifetime.
Mastectomies and the resultant breast reconstruction.
Professional ambulance services.
Treatment of mental disorders, alcoholism, and substance abuse.
Chiropractic services up to $1,800 per individual per calendar year.
Durable medical and surgical equipment rental.
Artificial limbs and eyes including their fitting.
Anesthetics and oxygen.
Self-injectable drugs for insulin, epi-pens, and heparin. Other self-injectable drugs must be pre-authorized by Cigna.
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 a gender affirmation surgery or treatment of gender dysphoria.
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.
Reversal of a sterilization procedure.
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).
Orthopaedic laser therapy treatment.

Submitting Your Claim Forms

All qualifying claims (medical, vision, dental and prescription drugs) 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 by logging in your Cigna Personal Webpage Account. Please remember to scan or take a picture of your medical invoices and other supporting documents in advance so you can attach them to your claim in your Cigna Personal Webpage account. For more information about the online claims process, please refer to "Claim Procedure" on AIARC's website.

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.

You can also submit a claim by taking a picture of your invoice with your smart phone or tablet via the Cigna Health Benefits App. The Cigna Health Benefits App can be downloaded to your phone from Apple's App Store℠ or Android's Google Play™.

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:

- the employer plan that covers its employee is always primary to the plan that covers the employee as a dependent, and
- the primary plan for a dependent who is covered by both parents' plans will be the plan of the parent whose birth month/day is earlier in the year.

Fraud

A participant may be expelled from the Plan for fraudulent acts committed against the Plan. Participants include the employee, retired employee, spouse, domestic partner or any dependent. An expulsion will result in all participants associated with the primary Plan member being expelled.

Key Contacts

It is recommended that you establish your Cigna Personal Webpage account before you need to use it. It is also recommended that you enter Cigna's contact information, e.g., website, email, and phone number into your mobile phone for quick access in case of an emergency.

Cigna (Medical, Vision and Dental)	
Cigna Electronic Membership Card	• Cigna Personal Webpage - Cigna Health Benefits (www.cignahealthbenefits.com) • **Cigna Health Benefits App (**Download the free App from the Apple App Store℠ or Google Play™ for Android™)
In-Network Provider Search	• To find in-network providers outside of U.S., go to website - Cigna Health Benefits (www.cignahealthbenefits.com) • To find in-network providers in the U.S. go to website - Cigna Health Care Provider Directory (hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC033)
Telehealth Services • **Employee Assistance Program (EAP)** • **Cigna Wellbeing App**	• Access to doctors for non-emergency health issues, EAP, and prescriptions • Download the free Cigna Wellbeing App from the Apple App Store℠ or Google Play™ for Android™.
Cigna Contact Centers	• +32–3–217–6947 (Antwerp, Belgium) — 24/7 Contact Center • +1–866–253–3003 (Miami, US) — 24/7 Contact Center • +254-203-617-314 (Kenya Local Office)
Fax	• +32–3–663–2857 (Belgium)
Email:	• aiarc@cigna.com (for all inquiries) authorization@cigna.com (request for guarantee of payments)
Cigna (U.S. Prescription Drugs)	
U.S. Retail Pharmacy Information	• RXGRP NRBA, RX issuer (80840), Rx Bin 017010, and RX PCN 0216INTL (required for 30-day supply)
Cigna Home Delivery - Express Scripts Pharmacy (90-day supply)	• www.express-scripts.com • 1–800–835–3784 (in the U.S.) • 001 605 373 0100 (outside the U.S)
Cigna Claims	
Electronic claims Website or Health Benefits App	• www.cignahealthbenefits.com • **Cigna Health Benefits App (**Download the free App from the Apple App Store℠ or Google Play™ for Android)