



**Medical Benefits Plan (MBP) for
International Monetary Fund (Control #706362)
Administered by Aetna International
Effective Date: January 1, 2026**

Eligibility Provision			
Employee	Covers Staff, Contractuals, Bretton Woods, Office Executives Directors, LTXs, Retirees and Dependents electing Open Choice Medical, Dental and Prescription Drugs.		
Dependent	Wife or husband; same or opposite sex domestic partner; children up to age 26, regardless of student status.		
Medical			
PLAN FEATURES		In the U.S.	
	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Individual Deductible	\$300	\$300	\$300
Family Deductible	\$600	\$600	\$600
Individual Payment Limit	\$2,500	\$2,500	\$2,500
(Includes all copays and all Deductibles, does not include the separate Prescription Drug Coinsurance limit.)			
Family Payment Limit	\$5,000	\$5,000	\$5,000
(Includes all copays and all Deductibles, does not include the separate Prescription Drug Coinsurance limit.)			
Lifetime Maximum	Unlimited		
Member Payment Percentages			
Hospital Services			
Inpatient	10% after deductible	10% after deductible	20% after deductible
Outpatient	10% after deductible	10% after deductible	20% after deductible
Private Room Limit	The institution's semiprivate rate		
Non-Emergency Use of the Emergency Room	10% after deductible	10% after deductible	10% after deductible
Emergency Room	10% after deductible	10% after deductible	10% after deductible
Non-Urgent Use of Urgent Care Provider	10% after deductible	10% after deductible	20% after deductible
Urgent Care	10% after deductible	10% after deductible	20% after deductible
Ambulance	10% after deductible	10% after deductible	10% after deductible
Physician Services			
PCP Office Visit	No charge	No charge after \$20 copay	20% after deductible
Specialist Office Visit	No charge	No charge after \$20 copay	20% after deductible
Teledoc	No coverage	No charge after \$20 copay	No coverage

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Member Payment Percentages			
Mental Health Services			
Mental Health Inpatient Coverage	10% after deductible	10% after deductible	20% after deductible
(Unlimited days per calendar year)			
Mental Health Outpatient Coverage	No charge	No charge after \$20 copay	No charge after \$20 per visit
(Unlimited visits per calendar year, subject to Aetna’s review for medical necessity)			
Alcohol/Drug Abuse Services			
Substance Abuse Inpatient Coverage	10% after deductible	10% after deductible	20% after deductible
(Unlimited days per calendar year, subject to Aetna’s review for medical necessity)			
Substance Abuse Outpatient Coverage	No charge	No charge after \$20 copay	20% after deductible
(Unlimited visits per calendar year, submit to Aetna’s review for medical necessity)			
Other Services			
Skilled Nursing Facility (Unlimited per calendar year, subject to Aetna’s review for medical necessity)	10% after deductible	10% after deductible	20% after deductible
Hospice Care Facility Inpatient (Unlimited lifetime maximum)	10% after deductible	10% after deductible	20% after deductible
Hospice Care Facility Outpatient (Unlimited lifetime maximum)	10% after deductible	10% after deductible	20% after deductible
Home Health Care (Unlimited visits per calendar year, subject to Aetna’s review for medical necessity)	10% after deductible	10% after deductible	20% after deductible
Private Duty Nursing (Unlimited shifts per calendar year, subject to Aetna’s review for medical necessity)	10% after deductible	10% after deductible	20% after deductible
Spinal Disorder Treatment (Unlimited visits per calendar year, subject to Aetna’s review for medical necessity)	No charge	No charge after \$20 copay	20% after deductible
Short Term Rehabilitation	No charge	No charge after \$20 copay	20% after deductible
(Includes coverage for Occupational, Physical and Speech Therapies; Unlimited visits per calendar year, subject to Aetna’s review for medical necessity)			
Diagnostic Outpatient X-ray	10% after deductible	10% after deductible	20% after deductible
Diagnostic Outpatient Lab	10% after deductible	10% after deductible	20% after deductible

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Member Payment Percentages			
Other Services			
Infertility Services	10% after deductible	10% after deductible	20% after deductible
(includes Artificial Insemination and Ovulation Induction – 6 attempts per lifetime. InVitro Fertilization, GIFT, ZIFT, Cryogenic Embryo Transfer &ICSI limited to \$50,000 per lifetime). Plan allows for Out-of-Network Pharmacy same as In-Network.			
Autism Member cost sharing is based on the type of service performed and the place of service where it is rendered	Autism covered same as any other expense for children to age 18.		
(Subject to medical necessity and requires pre-certification)			
Routine Hearing Exam Includes one routine exam every 2 calendar years.	No charge	No charge	No charge
Hearing Aids	No charge	No charge after \$20 copay	20% after deductible
Hearing Aids - \$4,500 allowance once every 4 years for the purchase of hearing aids (unlimited coverage only if hearing loss is due to an accident)			
Acupuncture	10% after deductible	10% after deductible	20% after deductible
Bariatric Surgery	10% after deductible	10% after deductible	No Coverage
Wellness Benefits			
Routine Children Physical Exams	No charge	No charge	No charge
Child to age 36 months no frequency limit; Child age 36 months and older, 1 exam per calendar year			
Routine Adult Physical Exams	No charge	No charge	No charge
Employee and Spouse 1 exam per calendar year			
Routine Gynecological Exams	No charge	No charge	No charge
Includes 1 exam and pap smear per calendar year			
Mammograms (1 routine mammogram per calendar year, no age limit)	No charge	No charge	No charge
Prostate Specific Antigen (PSA)	No charge	No charge	No charge
Includes 1 PSA per calendar year for males, no age limit			
Digital Rectal Exam (DRE)	No charge	No charge	No charge
Includes 1 DRE per calendar year for males, no age limit			
Cancer Screening	No charge	No charge	No charge
Recommended: Members age 45 and older			
Vision Expenses			
Routine Eye Exam	No charge	No charge	No charge
(Covered under medical) Includes one routine exam per calendar year.			
Vision Care Supplies (except for accidental injury, glaucoma, cataracts, and strabismus)	No charge up to \$600 maximum	No charge up to \$600 maximum	No charge up to \$600 maximum
Schedule maximum apply every 24 months starting with first expense for the purchase of prescribed eyeglass lenses, frames and contact lenses. Ex: You use the benefits March 10, 2025, you will be eligible again March 10, 2027.			

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Member Payment Percentages			
Vision Care Supplies (for accidental injury, glaucoma, cataracts, and strabismus)	10% after deductible	10% after deductible	20% after deductible
Prescription Drug Coverage			
Individual Coinsurance Limit (this is a separate limit from the Medical Payment Limit)	\$1,000 per calendar year	\$1,000 per calendar year	No Coverage
Family Coinsurance Limit (this is a separate limit from the Medical Payment Limit)	\$2,000 per calendar year	\$2,000 per calendar year	No Coverage
Retail Generic Drugs (365 day maximum supply) Includes contraceptives	10% coinsurance No deductible applies	10% coinsurance No deductible applies	No Coverage
Retail Formulary Brand Name Drugs (365 day maximum supply) Includes contraceptives	10% coinsurance No deductible applies	15% coinsurance No deductible applies	No Coverage
Retail Non-Formulary Brand Name Drugs (365 day maximum supply) Includes contraceptives	10% coinsurance No deductible applies	25% coinsurance No deductible applies	No Coverage
Mail Order - Generic Drugs (365 day maximum supply) Includes contraceptives	10% coinsurance No deductible applies	6.67% coinsurance No deductible applies	No Coverage
Mail Order - Formulary Brand Name Drugs (365 day maximum supply) Includes contraceptives	10% coinsurance No deductible applies	10% coinsurance No deductible applies	No Coverage
Mail Order – Non-Formulary Brand Name Drugs (365 day maximum supply) Includes contraceptives	10% coinsurance No deductible applies	16.67% coinsurance No deductible applies	No Coverage

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Dental			
PLAN FEATURES	OUTSIDE THE U.S.	In the U.S.	
		Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Individual Deductible	\$200	\$200	\$200
Family Deductible	\$500	\$500	\$500
Type A Expense <i>(Diagnostic & Preventive)</i>	No charge	No charge	No charge
Type B Expense <i>(Basic Restorative)</i>	20% after deductible	20% after deductible	20% after deductible
Type C Expense <i>(Major Restorative)</i>	20% after deductible	20% after deductible	20% after deductible
Orthodontics <i>(Employees, Spouse & Dependent children)</i>	20%	20%	20%
Calendar Year Maximum	\$5,000	\$5,000	\$5,000
Orthodontic Lifetime Maximum	\$3,000	\$3,000	\$3,000
Services and Programs included			
Informed Health Line (24-hour nurse line)			
vHealth Members outside the U.S. have access to anytime, on-demand, virtual care. Schedule convenient and cost-effective appointments with health care professionals by phone and online video.			

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Medical Plan Caveats

There is cross-application between calendar year deductible, out of pocket maximum and lifetime maximum across overseas, in-network and out-of-network level of benefits.

Coverage maximums up to a certain number of days/visits per calendar year are reached by combining the Preferred and Non-Preferred benefits up to the limit for either one plan or the other, but not both. (Example, if the Preferred benefit is for 120 days and the Non-Preferred benefit is for 120 days, the maximum benefit is 120 days, not 240 days).

Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and spouse and all female family members. Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.

For contracted hospitals, the non-contracted Radiologist, Anesthesiologist and Pathologist (RAPS) are paid at the preferred level, and will be subject to Recognized charges. Note that this payment method may apply to other providers.

Payment of Out-of-Network services are subject to reasonable and customary charges, member may be billed for any amounts in excess of those charges.

Benefit maximums per Calendar year are calculated between January - December.

This is only a brief summary of the Medical and Dental benefits available. Some restrictions may apply.

For more specific information about the coverage details, including limitations, exclusions and other plan requirements, please refer to the employee booklet.

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