Medical Benefits Plan

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Plan Document

International Monetary Fund
Washington, D.C.

January 1, 2011

Medical Benefits Plan of the International Monetary Fund

TABLE OF CONTENTS

ARTICLE I

INTRODUCTION

This plan document describes the benefits and the administrative provisions of the Medical Benefits Plan ("MBP" or the "Plan") of the International Monetary Fund ("the Fund"). The MBP is a health benefits program providing worldwide benefits for medical, dental and prescription drug expenses resulting from nonoccupational illness or injury. The MBP was adopted May 1, 1967 and was last amended effective January 1, 2011. The benefits offered are described in various documentation (referred to herein as "Incorporated Documents"), which are incorporated into this plan document. This document, together with the documentation incorporated by reference into it, is the official statement of the benefits and administrative provisions of the MBP. In case of conflict between this document and any of the Incorporated Documents, the terms of this document shall govern. No other written document, unless approved by Management or the Executive Board, and no oral statement can modify or otherwise affect the benefits, limitations, exclusions and administrative provisions described in this plan document.

ARTICLE II

DEFINITIONS

2.1 Actively at Work

"Actively at Work" means that on a specified day, an Employee is not absent from work on account of an occupational or nonoccupational illness or injury, or on leave of absence for personal reasons and the Employee is physically capable of performing the regular duties of his occupation. "Actively at Work" includes periods of annual leave, leave without pay in the interest of the IMF and Employer approved work study programs, as described in the Employer's General Administrative Order No. 7, as it may be revised from time to time.

2.2 Allowable Expenses

"Allowable Expenses" are that portion of a Covered Expense equal to the negotiated charge for provider network services or the Claims Administrator's recognized charge for out-of-network services incurred by a Participant for the health care services and items described in the Incorporated Documents.

2.3 Approved Form

"Approved Form" means a form approved by the Plan Administrator for a particular communication or administration purpose under the Plan. Approved Forms may be paper, electronic or any other media approved by the Plan Administrator.

2.4 Beneficiary

"Beneficiary" means the person for whom a Benefit may or will be paid in accordance with the terms of the Plan. A Beneficiary can include the Participant, eligible Dependent and Other Dependent.

2.5 Benefit

"Benefit" means a payment or reimbursement on account of Coverage.

2.6 Claim

"Claim" means a claim for a Benefit.

2.7 Claimant

"Claimant" means a person who files a Claim.

2.8 Claims Administrator

"Claims Administrator" is one or more persons or entities chosen by the IMF to adjudicate and pay medical, dental and prescription drug Claims. The current Claims Administrators are as follows:

- For United States based Participants for medical, dental and prescription drug Claims, Aetna Global Benefits/Aetna, P.O. Box 981543, El Paso, TX, USA 79998-1543.

- For Participants based outside of the United States, for medical, dental and prescription drug Claims, Van Breda International, Plantin & Moretuslei 299, 2140 Antwerpen, Belgium. Postbox 69, 2140 Antwerpen.

Specific contact information for each Claims Administrator is identified in the applicable Incorporated Document.

2.9 Continuation Period

"Continuation Period," when used in connection with the Extension Option, is the time during which a Qualified Beneficiary may continue to be covered under the Plan's Extension Option. The Continuation Period begins on the date of a Qualifying Event and ends 18 months later (36 months later if the Qualifying Event is divorce). The Continuation Period begins on the date of the Qualifying Event whether or not continuation of Coverage is provided under another section of the Plan.

2.10 Coverage

"Coverage" means an entitlement to the Benefits available to a Beneficiary for Allowable Expenses that are incurred when Coverage is in effect.

2.11 Covered Expenses

"Covered Expense" means a cost incurred for the purchase of Covered Services provided to a Participant or a Dependent during a period of Coverage.

2.12 Covered Services

"Covered Services" means those services and items described in Incorporated Documents that are performed by a Provider. The Claims Administrator determines which procedures or treatments are included in which category of Covered Services. Covered Services are deemed to be provided on the date a Participant or Dependent actually receives the Covered Services except for special circumstances under orthodontia.

2.13 Deductible

The medical and dental deductibles consist of the Allowable Expenses which the Participant must pay each calendar year before Plan Benefits are payable. There are separate deductibles for the medical and dental provisions of the Plan.

If a person covered under the Plan incurs Allowable Expenses during the last quarter of any Plan Year that are used to satisfy all or any part of the dental deductible amounts, those charges will also count toward meeting the dental deductible for that person for the next Plan Year. Allowable Expenses that are incurred in the last quarter of the Plan Year and that are in excess of the dental deductible for that Year are not carried over to meet the deductible for the following Year.

For Participants of the Paris Office paid in local currency, the deductible is determined as of each January first by converting the U.S. dollar deductible into euros. The deductible is then fixed for the remainder of the year.

For other Participants residing outside of the United States, the U.S. dollar deductible is used. See Section 8.7 for how expenses incurred in currencies other than the U.S. dollar are converted to the U.S. dollar for application to the deductible.

2.14 Dependent

"Dependent" is a Participant's Spouse, Domestic Partner or Dependent Child.

2.15 Dependent Child

"Dependent Child" is a Participant's natural child, legally adopted child (including a child placed in a Participant's home pending final adoption), or step-child who is under 26 years of age, regardless of financial or marital status. Step-child shall mean the natural child or legally adopted child of the Spouse or Domestic Partner of the Participant.

A Dependent Child who is or who becomes incapable of self-support because of a mental or physical disability and who depends on the Participant for over half his support will be a Dependent Child as long as such incapacity and dependency exist.

2.16 Disabled Person

"Disabled Person" is a person who is permanently and totally disabled under the Employer's Staff Retirement Plan.

2.17 Domestic Partner

"Domestic Partner" is one who has been registered as such by the Participant and accepted according to the Fund's procedures for such registration, which may be found at the relevant section of General Administrative Order No. 28, Rev. 6, Section 4.01.

2.18 Election

"Election" refers to the choice made by a person eligible under Article 3 to make requests to commence, increase or decrease Coverage, or to elect no Coverage (even by default), for a period of Coverage. An Election is deemed to be made on the Election Date.

2.19 Election Procedure

"Election Procedure" means the procedure by which a person makes an Election. The Election Procedure will be determined by the Plan Administrator, and may be changed by the Plan Administrator at any time.

2.20 Eligibility Date

"Eligibility Date" means the date on which a person becomes eligible for Coverage on account of being hired, transferred, or returning from leave without pay, where Coverage was terminated upon commencement of the leave. In the case of Dependents, Eligibility Date refers to the life event such as the birth, or adoption of the Dependent Child, or the marriage, or registration of a Domestic Partnership. In the case of a handicapped Dependent Child, Eligibility Date means the later of the Employee's Eligibility Date or the date of incapacity, as determined by the Claims Administrator. The Eligibility Date of a newly hired Employee and such Employee's Dependents will be the Employee's current employment or entry on duty date. If such Dependents do not initially reside with the Employee at the duty station, then the Dependents' arrival date at the duty station will be their Eligibility Date. The Eligibility Date of an Employee who has been newly transferred from an ineligible employment classification will be the effective date of the Employee's transfer. Except as otherwise provided in the Plan, the Eligibility Date of a person returning from leave without pay will be the first day the Employee is Actively at Work following the date the leave of absence ended.

2.21 Employee

"Employee" is any person who is

(A) employed by the Employer as a regular, limited-term or fixed-term staff member (full or part-time);

(B) Managing Director;

(C) a contractual appointee, provided that eligibility to participate is specified in the letter of appointment;

(D) Executive Director, Alternate Executive Director, Senior Advisor or Advisor to Executive Director;

(E) Assistant to Executive Director;

(F) special appointee;

(G) Technical Assistance Expert or Advisor, on a long-term assignment; or

(H) persons employed abroad by the Employer as determined by the Plan Administrator; and

(I) full-time employees of Bretton Woods Recreation Center.

"Employee" does not include staff hired locally to work in the office of a Resident Representative or Overseas Office or Regional Technical Assistance Center.

"Employee" does not mean any of the following persons, even if determined retroactively to be a common-law employee:

A. a self-employed individual, as defined in U.S. Internal Revenue Code Section 401(c)(1)(A);

B. a member of the Board of Governors who is not otherwise an Employee;

C. a person the Plan Administrator determines is the Employer's independent contractor; or

D. a person the Plan Administrator determines the Employer engages as a consultant or advisor on a retainer or fee basis.

2.22 Employer

"Employer" is the International Monetary Fund, or "IMF" or "Fund."

2.23 Executive Board

"Executive Board" means the Executive Board of the IMF, and relevant Committees thereof.

2.24 IMF Institute Participant

"IMF Institute Participant" means a person who is not an Employee and who is enrolled in a course offered by or through the IMF Institute.

2.25 Incorporated Document

"Incorporated Document" means an insurance policy, plan, trust, summary plan description or other document incorporated by reference, together with any exhibits, supplements, addendums or amendments thereto. Currently, Incorporated Documents include the following:

- Medical Benefits Plan—Schedule of Medical, Prescription Drug and Dental Benefits, effective January 1, 2011—full coverage for Active Employees, Technical Staff (Experts and Advisors) Retirees and Survivors (Aetna Global Benefits);

- Medical Benefits Plan—Schedule of Medical, Prescription Drug and Dental Benefits, effective January 1, 2011—limited coverage for Active Employees and Technical Staff (Experts and Advisors) (Aetna Global Benefits);

- Medical Benefits Plan – Schedule of Medical, Prescription Drug and Dental Benefits, effective January 1, 2011—for IMF Institute Participants (Aetna Global Benefits);

- Aetna's Summary Plan Description of the Medical Benefits Plan;

- Vanbreda International's Summary of The International Monetary Fund's Medical Benefits Plan for Participants Residing Outside of the United States.

2.26 Limited Coverage

"Limited Coverage" means that the Plan will **not** cover expenses incurred by the Participant or his Dependents enrolled for such coverage for the following:

- Maternity care
- Psychiatric care
- Routine vision care
- Routine dental care
- Substance abuse

2.27 Medicare

"Medicare" is the program sponsored by the United States government that provides hospital, medical—surgical and prescription drug Benefits for the aged and disabled under the United States Social Security Act, 42 U.S.C. sections 1395 et seq.

2.28 Other Dependent

"Other Dependent" is a parent or parent-in-law who meets each of the requirements listed below. No more than two such dependents may be covered at any one time.

A. They must reside permanently in the Participant's household. For purposes of the MBP, parents or parents-in-law are deemed to reside permanently in the Participant's household only if they actually live with the Participant in his home on a full-time basis for at least nine months per year.

B. If visas are required, they must have a visa permitting an indefinite stay in the United States. A copy of the visa must be submitted with the enrollment application.

C. They must receive more than 50 percent of their support from the Participant, or from the Participant and his Spouse/domestic partner jointly, and earn less than $1,000 in a calendar year, not including pensions.

2.29 Participant

"Participant" is an eligible Employee, Retiree, Disabled Person, Survivor or Qualified Beneficiary who is enrolled and has Elected to participate in the Plan. "Participant" includes IMF Institute Participants even though Coverage is automatic and does not require an Election to enroll in the Plan.

2.30 Participation Service

For the purpose of eligibility for Coverage in retirement and while a Participant is on leave of absence, "Participation Service" means a period of Coverage under the Plan, including periods of Coverage while covered as a Qualified Beneficiary. A year of Coverage as an Employee working a part-time schedule is treated as equal to a year of Coverage as an Employee working a full-time schedule.

The minimum period of Plan participation includes periods of participation under a contractual or staff appointment, provided however that MBP participation during a period of contractual employment following employment as a staff member shall not count towards the eligibility requirements of the Plan.

For purposes of Participation Service under the Plan, each Employee who was previously an active employee of an international organization with which the Fund had a pension transfer agreement in effect, at the time of such employment elected to transfer their pension rights under such agreement and who participated in such organization's health plan(s), will receive credit for such participation under the Plan. These organizations have included the World Bank, the United Nations, the Inter-American Development Bank, and the Asian Development Bank.

2.31 Plan

"Plan" is the Medical Benefits Plan of the International Monetary Fund, which is also referred to as the MBP.

2.32 Plan Administrator

"Plan Administrator" is the person authorized to control and manage the operation and administration of the Plan. The current Plan Administrator is the Director, Human Resources Department, International Monetary Fund.

2.33 Plan Year

"Plan Year" is the calendar year.

2.34 Qualified Beneficiary (with respect to eligibility for the Extension Option)

"Qualified Beneficiary" is an Employee, Retiree, or Disabled Person, with at least one year of Participation Service in the Plan, or a Dependent of any of the foregoing, who is covered under the Plan on the day before a Qualifying Event. A Qualified Beneficiary is eligible for Coverage under the Continuation Period afforded by the Plan's Extension Option.

2.35 Qualifying Event (with respect to eligibility for the Extension Option)

"Qualifying Event" is one of the following events:

A. death of a covered Employee, Retiree, or Disabled Person;

B. termination of employment of a covered Employee other than for misconduct;

C. divorce, separation or termination of Domestic Partnership of a covered Employee, Retiree, or Disabled Person;

D. a Dependent Child's loss of status as a Dependent Child under the Plan;

E. termination of the Spouse's or Domestic Partner's employment (voluntary or involuntary), resulting in a loss of health insurance coverage;

F. a change in the Spouse's or Domestic Partner's employment status to one where medical Coverage is not available; and

G. the loss of Coverage of the Employee, Retiree, or Disabled Person as a result of separation, divorce, termination of Domestic Partnership, or the death of the Spouse or Domestic Partner.

Documentary proof of a Qualifying Event is required by the Plan Administrator or his agents and can consist of copies of legal separation agreements, divorce decrees, the Employer's Declaration of Termination of Domestic Partnership form, or death certificates, as well as a statement from the prior insurer/administrator concerning the termination of eligibility for Coverage.

2.36 Retiree

"Retiree," as used in this Plan, is a former Employee who satisfies either A, B, C, D, or E below:

A. A former Employee who is entitled to receive an immediate pension or elect a deferred pension under the Fund's Staff Retirement Plan, and who:

1. separated at age 50 or older, with at least five years or more of Participation Service in the Plan, excluding periods as a contractual appointee following appointments as a staff member, and who maintained Coverage in the Plan continuously from the date of separation from employment through the commencement of his retirement benefits, i.e., no break in Participation Service following the conclusion of employment and the commencement of retirement benefits for those who elect a deferred pension;[1] or

2. separated from employment at age 62 or older other than by resignation, has been continuously enrolled in the Plan throughout his Fund employment and, in the case of a former Employee who was a staff member, had either an open-ended (regular) appointment or fixed- or limited-term appointment of at least three years. A staff member who resigns must complete a full five years of Participation Service in the Plan, excluding periods as a contractual appointee

[1] Any Retiree as defined in Section 2.36 who was at least age 50 at the time of separation from employment with the Employer, but who has less than five years of participation in the Plan, may use the 18-month post-employment Extension Option to meet the minimum five year participation requirement.

following appointments as a staff member, in order to be eligible for post-retirement Coverage. For purposes of this provision, resignation for reasons that are beyond the control of the Employee shall satisfy the requirements set forth in this provision; or

3. separated at any age if disabled under the provisions of the Fund's Staff Retirement Plan and was a Participant in the Plan; or

4. took up his position at the Fund after his 62nd birthday and who did not participate in, and is not entitled to a pension from, the SRP for the sole reason that he took up his position after age 62, but who satisfies all other eligibility requirements for post-retirement coverage set out in Section 2.36 above.

B. Persons who were Employees on or before January 1, 2002, who were eligible to participate in the Fund's Staff Retirement Plan, and who were either already age 62 or older, or who have since separated or will separate after reaching age 62 with less than 10 years of Participation service, are grandfathered for Coverage in retirement.

C. In addition, persons who were Employees on or before January 1, 2002, who were eligible to participate in the Fund's Staff Retirement Plan, and who have since separated or will separate after reaching age 55, but before reaching age 62, with at least 10 years of Fund service but less than five years of Participation service, are grandfathered for Coverage in retirement if they enrolled in the Plan by February 11, 2002.

D. Former Employees who were covered under the post-employment Extension Option as of January 1, 2002 and who met the eligibility rules on separation age and Participation service are also considered "Retirees." The 18-month post-employment Continuation Period may be used to meet the minimum participation requirement.

E. For Former Employees who separated in the context of the downsizing beginning May 2008 through FY2011 only, the period of separation leave to which a staff member is entitled may be counted toward retiree medical coverage eligibility under the MBP even if Separation Benefit Fund (SBF) entitlements are taken as a lump sum instead of separation leave or the staff member elects a deferred pension under the Rule of Age 50 and waives his/her SBF entitlements; and with respect to staff separating in the context of the downsizing in FY2009-FY2011 only, staff members who take the 18-month extension option may elect an additional 18 months of MBP coverage, for a total extension option period of 36 months. The additional 18-month period of coverage will be on the same terms

and conditions as the initial18 months, but will not count toward retiree medical eligibility.

2.37 Short-Term Contractual Employee

"Short-Term Contractual Employee" is a person who is hired by the Employer for the specified purpose of meeting short-term needs of less than three months and who is designated as a Short-Term Contractual Employee when hired.

2.38 Spouse

"Spouse" is a Participant's partner, including a same-sex partner, in a marital relationship recognized by the Employer under the relevant section of General Administrative Order No. 28, Rev. 6, Section 4, as it may be revised from time to time.

2.39 Survivor

"Survivor" is a person who was an Employee's, Retiree's, or Disabled Person's Spouse or, if there was no Spouse, Domestic Partner, or Dependent Child at the Employee's, Retiree's, or Disabled Person's death, provided that the deceased Employee or Retiree was a participant in the Employer's Staff Retirement Plan at the time of death.

ARTICLE III

ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATES

3.1 Persons Eligible to Participate

Each of the persons described below is eligible to participate in the Plan, subject to the enrollment requirements described in this Article:

A. Employees

B. Retirees

C. Disabled Persons

D. Survivors

E. IMF Institute Participants

Short-Term Contractual Employees are not eligible to participate in the Plan pursuant to this section or pursuant to Section 3.2. Short-Term Contractual Employees are eligible to participate in the Short-Term Medical Insurance Program.

3.2 Persons Eligible to Participate with Limited Coverage

Each of the following **Employees** is eligible to participate in the Plan with Limited Coverage only:

(i) a contractual appointee with a full-time appointment of less than one year but, not a Technical Assistance Expert or Long Term Expert who is eligible for full Coverage; and

(ii) a contractual appointee with a part-time appointment of one year or less, but not a Technical Assistance Expert or Long Term Expert who is eligible for full Coverage.

Eligibility is determined by a person's employment category and must be specified in an appointment letter. A person eligible for Limited Coverage must enroll in the Plan with Limited Coverage to participate in the Plan, and is not eligible to enroll in any Benefit other than the Limited Coverage described in this Section.

3.3 Enrollment and Effective Dates for Employees

Enrollment in the Plan is accomplished by the Employee making an Election to participate on an Approved Form and following the Election Procedure described in the various sections below.

A. Upon enrollment within 31 days of the Eligibility Date, Coverage is effective on the entry on duty date provided that a person is Actively at Work.

B. For an Employee who makes an Election later than 31 days of the entry on duty date, Coverage is effective the first day of the month following approval by the Claims Administrator of evidence of good health submitted by the Employee with his Election, except as provided in Sections 3.11 B and 3.12, and the Employee is Actively at Work.

C. An Employee who makes an Election after cancellation of Coverage is also subject to the Election, Actively at Work and evidence of good health requirements described in (b), except as provided in Sections 3.11 B and 3.12.

D. Notwithstanding subsections (a) and (b) above, an Employee or Dependent is eligible for immediate Coverage if the Employee applies within 31 days following his or his Spouse's or Domestic Partner's loss of group coverage from another employer, because the Employee or Dependent is no longer eligible for such coverage. The Employee must be Actively at Work for Coverage to become effective. In addition, an Employee is eligible for Coverage under this subsection if there are changes in the type of coverage provided under the other employer's health plan which adversely affect access to the health care that the Employee or Dependent is accustomed to, or if there is a loss of Coverage as a result of separation, divorce, termination of Domestic Partnership, or death of the Employee's Spouse or Domestic Partner.

Proof of such loss will need to be supplied by the Participant at the time of the Employee's and Dependent's enrollment. Such proof can consist of legal separation agreements, divorce decrees, the Employer's Termination of Domestic Partnership form, death certificate, statement from the prior employer or insurer/administrator concerning the termination of eligibility for coverage, or significant changes in health benefits provided.

3.4 Enrollment and Effective Dates for Retirees

All Retirees and their Dependents meeting the eligibility requirements of Section 3.1 shall be enrolled in the Plan upon making an Election to participate on an Approved Form, e.g., Payments Upon Separation or Retirement. If a Retiree fails to enroll or

fails to enroll a Dependent within 31 days of first being eligible to enroll in the Plan upon retirement from the Fund, the Retiree may not elect to enroll at a later date.

A. A Retiree can continue Coverage if he is a Participant on the effective date of retirement, subject to the provisions of Section 2.36.

B. A Retiree who has single Coverage or one-parent family Coverage may apply to add a Spouse, or Dependent Child following the effective date of retirement provided the criteria in Section 3.10 are satisfied.

3.5 Enrollment and Effective Dates for Disabled Persons

All Disabled Persons and their Dependents meeting the eligibility requirements of Section 3.1 shall be enrolled in the Benefits upon making an Election to participate on an Approved Form. If a Disabled Person fails to enroll or fails to enroll a Dependent within 31 days of first being eligible to enroll in Medical Benefits upon retirement from the IMF, the Disabled Person may not elect to enroll at a later date.

A. A Disabled Person can continue Coverage until he is no longer a Disabled Person if he is a Participant on his effective date of disability.

B. A Disabled Person who is not a Participant on the effective date of disability is not eligible for Coverage unless he recovers and is again Actively at Work on a regular basis.

C. A Disabled Person who cancels Coverage is not eligible to reenroll unless he recovers and is Actively at Work on a regular basis.

3.6 Enrollment and Effective Dates for Survivors

Survivors, as described below, are eligible to continue Coverage. They must apply **using an Approved Form** for the continuation of Coverage within 31 days from the Participant's date of death. Coverage is continuous from the date of the Participant's death as long as the Survivor pays the contribution required by the IMF.

A. A Survivor, who is covered by the Plan at the time of the Participant's death, is eligible for continued Coverage as follows:

1. Spouse—until death

2. Domestic Partner—until death

3. Dependent Child—until he ceases to qualify as a Dependent Child

B. Survivors of a Participant who dies while on a leave of absence without pay are eligible to apply for continued coverage, provided the Participant remained enrolled in the Plan during the period of leave without pay, and if they are eligible to receive a pension under the Fund's Staff Retirement Plan.

C. A person who is eligible for Plan Coverage as an Employee or a Disabled Person is not eligible for Coverage as a Survivor. A person who is eligible for Plan Coverage as a Retiree is not eligible for Coverage as a Survivor, except as approved by the Plan Administrator.

D. A Survivor whose Coverage is canceled for nonpayment of a contribution is not eligible for reenrollment as a Survivor.

3.7 Enrollment and Effective Dates for Qualified Beneficiaries

The following section addresses enrollment and effective dates under the Extension Option, as described in Section 7.9:

A. Upon the occurrence of a Qualifying Event, a Qualified Beneficiary who is not covered under another group health care plan may elect to continue Coverage under the Plan. Plan Coverage will continue until the Qualified Beneficiary obtains Coverage under another group health care plan or until the Continuation Period expires, whichever occurs first.

B. If the Qualifying Event is divorce, separation, termination of Domestic Partnership, or disqualification of a Dependent Child, the Participant or Qualified Beneficiary will be notified of the opportunity to elect the Extension Option by the Claims Administrator no later than 60 days after the Qualifying Event. The Claims Administrator will send an Election form to the Qualified Beneficiary. The Qualified Beneficiary may obtain Plan Coverage, effective the date of the Qualifying Event, if he returns a completed Election form to the Claims Administrator within the later of 60 days after he receives the form or 60 days after the Qualifying Event.

C. If the Qualifying Event is death, or termination of employment, the Claims Administrator will send an Election form to the Qualified Beneficiary. The Qualified Beneficiary may obtain Plan Coverage, effective the date of the Qualifying Event, if he returns a completed Election form to the Claims Administrator within the later of 60 days after he receives the form or 60 days after the Qualifying Event.

D. A Qualified Beneficiary who does not elect Coverage when initially eligible may not elect such Coverage at a later date.

E. A Qualified Beneficiary whose Coverage is canceled for nonpayment of a contribution is not eligible for reenrollment as a Qualified Beneficiary.

3.8 Enrollment and Effective Dates for IMF Institute Participants

An IMF Institute Participant and his accompanying Dependents are eligible to be covered by the Plan. No separate enrollment procedures are required. IMF Institute Participants are covered only for the duration of their enrollment in an IMF Institute course. Details of their Coverage are contained in relevant Incorporated Document.

3.9 Eligibility as Employee and Spouse or Domestic Partner

If a Participant and his or her Spouse or Domestic Partner are both Employees eligible to make an Election for Plan Coverage:

1. Each may make an Election for single Coverage; or

2. One may make an Election for single Coverage provided the other does not make an Election for married couple Coverage under the Plan; or

3. One may make an Election for married couple Coverage, provided the other does not make an Election for Coverage under the Plan. When one person makes an Election for family or married couple Coverage, the other qualifies as a Dependent;

4. In the event of death or divorce, the person covered as a Dependent may elect Coverage in his or her own right.

3.10 Coverage of Dependents and Other Dependents

A. **General.** A Dependent is eligible for Coverage at the time the Participant becomes eligible for Coverage. However, only the Participant can enroll an eligible Dependent for Coverage; a Dependent cannot enroll for Coverage in his own right. Coverage of a Dependent of a Participant who makes an Election for other than single Coverage is generally effective at the time that the Participant's Coverage is effective.

B. **Marriage.** If a Participant marries, Plan Coverage of his new Dependent(s) is effective on the date of application if he applies within 31 days after the date of marriage. Plan Coverage is otherwise effective on the first of the month following approval by the Claims Administrator of the evidence of good health submitted on behalf of the Dependent.

C. **Domestic Partnership.** If a Participant registers a Domestic Partner under the Employer's procedures, Plan Coverage of his new Dependent(s) is effective on the date of application if he applies within 31 days after the date of registration with the Employer. Plan Coverage is otherwise effective on the first of the month following approval by the Claims Administrator of evidence of good health submitted on behalf of the Dependent.

D. **Other Dependent.** Other Dependents should be enrolled as soon as possible upon becoming eligible for Coverage. The Participant is required to pay the monthly contribution for the Other Dependent for a minimum period of three years (unless the Other Dependent dies within the three year period). Other Dependent Coverage covers only an Other Dependent and no more than two such Dependents can be covered at any one time. Other Dependent Coverage is elected and paid for entirely by the Participant, i.e., such Coverage is not subsidized by the Employer. In order to elect Other Dependent Coverage, the Participant must have elected at least Single Coverage.

E. **Divorce, Separation or Termination of Domestic Partnership.** Coverage of a Participant's Spouse or Domestic Partner is discontinued at the end of the month in which the divorce is final or the domestic partnership is terminated. Coverage of a Spouse from whom the Participant has separated may be discontinued if the Participant submits proof of the Spouse's other health insurance coverage, or the Spouse's written permission to drop Coverage. With respect to a Dependent Child under age 18, evidence of other health insurance coverage must be provided before Coverage can be cancelled. The former Spouse, separated Spouse, or former Domestic Partner may be eligible for continued Coverage under Section 7.9.

F. **Birth and Adoption.** Coverage of a Dependent Child is effective on the date of application to enroll, or in the case of a newborn child, from the date of birth, provided the Participant is already enrolled in the Plan with family Coverage. If the Participant has single or couple Coverage under the Plan at the time the child is born, the Participant must change to one- or two-parent family Coverage within 31 days of the child's birth in order to have medical expenses incurred by that child covered retroactively to the date of birth.

In the case of legal adoption, Coverage of a Dependent Child is effective on the date of application to enroll if application for two-parent or one-parent family Coverage is made within 31 days of the date physical custody is awarded, pending final adoption, subject to the review and approval of the Employer's Legal Department.

Coverage is otherwise effective on the first of the month following the approval by the Claims Administrator of the evidence of good health submitted on behalf of the Dependent.

G. **Handicapped children.** Participants may enroll, as a Dependent Child, an unmarried, totally handicapped child, incapable of self-sustaining employment, regardless of age and such Child who becomes totally handicapped within 31 days of such Child's Eligibility Date. To obtain or continue Coverage, acceptable proof of the child's incapacity must be submitted to the Claims Administrator at the time of enrollment. The Claims Administrator is responsible for determining whether the documentation submitted meets the criteria for providing Coverage under this section. Depending on the nature of the handicap, continued eligibility for this Coverage is subject to periodic review by the Claims Administrator.

H. **Qualified Beneficiary.** A person covered as a Qualified Beneficiary cannot be covered simultaneously as a Dependent. A Qualified Beneficiary is entitled to the unsubsidized Extension Option under Section 7.9, while a Participant's Dependent receives subsidized Coverage.

I. **Persons Recruited from Outside the Washington, D.C. Area.** An Employee recruited from outside the Washington, D.C. area must enroll in the Plan on behalf of himself and any eligible family members within 31 days of entering on duty in order to avoid the screening requirements required for a late enrollment.

If the Employee's Dependents still residing abroad at the time of the Employee's enrollment, he has the option of covering them under the Plan from the date of his own enrollment or of waiting until they actually arrive at the duty station, in which case the Employee must enroll them within 31 days of their arrival. However, Other Dependents who do not accompany the Employee on appointment travel may not be enrolled in the Plan until they actually join the Employee's household at the duty station.

3.11 Changes in Coverage

A. **Change in Type of Appointment**. An Employee on a fixed-term appointment who does not enroll in the Plan during the period of the fixed-term appointment will be given another opportunity to enroll himself and his Dependents if the appointment is later changed to a regular appointment. Upon the change in appointment, the Employee must enroll within 31 days of the date of the new appointment in order to avoid satisfying the requirements for late enrollment.

B. **Change from Limited to Full Coverage.** A Participant enrolled in the Plan with Limited Coverage may change to full Coverage only under the circumstances

described below. The procedure to be followed depends upon the set of circumstances under which the Participant qualifies for the change to full Coverage.

1. If a contractual appointment is converted to an employment category that entitles the Participant to full Coverage, his Coverage will be changed automatically as of the effective date of the new appointment.

2. If a Participant has a full-time appointment of less than 12 months that is subsequently extended for a cumulative period that totals at least 12 months, his Coverage will be changed automatically as of the effective date of the new appointment.

C. **Change in Type of Coverage by Participant**. When an Employee or a Disabled Person cancels his Coverage but his Spouse or Domestic Partner, who is also an Employee, enrolls for Coverage under the Plan, Coverage is continued for all persons who were covered under the cancelled Coverage and are eligible under the new Coverage if the Spouse or Domestic Partner enrolls within 31 days after the effective date of cancellation. The new Coverage will be effective on the day following the effective date of cancellation of the old Coverage. Normal eligibility and effective date rules apply if this condition is not met.

D. **Re-Enrollment.** If Coverage is canceled for any reason, a Participant and his Dependents will be required to submit evidence of good health acceptable to the Claim's Administrator before re-enrollment is permitted. Similarly, if Coverage for a Dependent is terminated for any reason, evidence of good health will be required before re-enrollment of the Dependent is permitted. The only exceptions to this rule are the following:

1. The requirement to submit evidence of good health is waived once per lifetime only for each Other Dependent who returns to resident dependency status and is re-enrolled in the Plan within 31 days of rejoining your household (with a visa permitting an indefinite stay in the United States, if a visa is required).

2. The requirement to submit evidence of good health is waived in the event of the Spouse's or Domestic Partner's loss of group coverage from another employer, because the Employee or Dependent is no longer eligible for such coverage. Re-enrollment must occur within 31 days following his or his Spouse's or Domestic Partner's loss of group coverage. Proof of such loss will need to be supplied by the Participant at the time of the Employee's and Dependent's re-enrollment.

3. Re-enrollment of Dependents is permitted prior to February 15, 2011.

E. **Wrong Coverage.** If a Participant has the wrong type of Coverage because of a lapse between cancellation and enrollment in a case under 3.11 C, or the loss or addition of a Dependent, the following rules apply:

1. Participant error or negligence:

    a. Past due contributions of up to six months from the date the error was discovered and acknowledged by the Employer must be paid by the Participant. Coverage will be in force as long as contributions are paid.

    b. Any contribution overpayment will not be refunded.

2. Employer error or negligence:

    a. Any past due contributions will be waived.

    b. Contribution overpayments of up to six months from the date the error was discovered and acknowledged by the Employer will be refunded.

3.12 Coverage Upon Return from a Leave of Absence

Coverage is continued upon return to work from a leave of absence for an Employee who maintained Coverage during such absence. An Employee who suspended Coverage during his absence may apply within 31 days after his return to work date. Coverage will be effective when he returns to work on a regular basis. For an Employee who applies later, Coverage is effective the first day of the month following approval by the Claims Administrator of evidence of good health submitted on **an Approved Form** by the Employee.

ARTICLE IV

BENEFITS

4.1 Plan Benefits

Beneficiaries shall have the right to the Plan benefits which include medical, dental and prescription drug benefits, described in the applicable Incorporated Document. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Incorporated Document. A description of such benefits, including the amount payable, required deductibles, co-payments, coinsurance, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Incorporated Document.

Except as expressly provided in an Incorporated Document, there is no lifetime maximum per Beneficiary on benefits payable by the Plan.

4.2 Lifetime Maximum Limit

Except as expressly provided in the Plan, there is no lifetime maximum per Participant or Dependent on Benefits payable by the Plan.

ARTICLE V

COORDINATION OF BENEFITS

5.1 Coordination of Benefits

Coordination of Benefits (COB) is a Claim payment procedure which may enable a Participant to receive, from all group health care plans (including government plans) under which he is covered, total payments up to but not exceeding 100 percent of total Allowable Expenses. (Such Allowable Expenses are those allowed in whole or in part by any plan, including the MBP). Generally, a Participant's primary plan pays full plan Benefits for the Claim. The secondary plan(s) may pay some or all of the difference between the amount paid by the primary plan and total covered expenses.

The Plan has adopted a coordination of Benefits regulation that conforms to the Model COB Regulation adopted by the National Association of Insurance Commissioners in June 1985, as modified. The specific rules used to determine the primary plan and coordinate benefits are described in the Incorporated Documents.

Expenses should be submitted to the primary plan first. Any balance remaining after payment by the primary plan should then be submitted to the secondary plan. In order to administer this section, the Employer and the Claims Administrator may exchange information about any Claim with the Claims Administrator of any other plan which covers the Participant. As part of this process, the Employer and the Claims Administrator may require the Participant to provide certain information, e.g., type of coverage, benefits and how claims were processed by the other plan.

For Plans other than Medicare and other national health schemes that coordinate like Medicare, when the MBP is secondary, the MBP will pay up to the amount it would have paid had it been the primary plan, provided the total amount paid does not exceed 100 percent of the Allowable Expenses.

5.2 Coordination with Medicare or Other Nationally-Sponsored Plans

When the other plan is nationally sponsored, the other plan will generally pay first. To the extent a Participant or the Participant's Spouse or Domestic Partner is working and they are ages 65 through 69 and are covered by Medicare as well as the MBP, the MBP will pay Benefits first, and Medicare will coordinate its Benefits with those paid under the MBP.

When coordinating with Medicare, the Claims Administrator may use Medicare's determination of Allowable Expenses (MAE) or the Plan's determination of Allowable

Expenses as the basis of determining whether and to what extent additional benefits are payable by the Plan. Three claim situations could arise:

- **Medicare Participating Provider—**The provider's charge cannot exceed MAE. Once paid by Medicare, the claim is processed by the Claims Administrator using MAE. The Retiree's Medicare out of pocket expense, i.e., coinsurance and deductibles, is based on MAE. The MBP would use MAE to determine what it would pay. With COB, up to 100 percent of MAE could be covered. MBP Allowable Expense is not relevant since there is no charge in excess of MAE.

- **Non-participating Provider**. If a provider chooses not to become a Medicare participating provider, he may either accept or decline assignment of Medicare benefits. If the provider accepts assignment, then COB is as described above for a participating Medicare provider. If the provider does not accept assignment, he cannot by law charge the Medicare Retiree more than 115 percent of the Medicare fee schedule. The Medicare Retiree is not responsible for billed amounts in excess of 115 percent of MAE. Medicare will pay its portion, and the Claims Administrator will process the balance based on the MBP's benefit provisions. The Claims Administrator would use the 115 percent of the fee schedule as the MAE. As with the Medicare participating provider, there is no MBP Allowable Expense to refer to for COB.

- **Providers who opt out of Medicare**. A provider opting out of Medicare enters into private contracts with Medicare Retirees. Under these contracts, the Retirees waive their rights to limit their payments to what Medicare allows, and they agree to pay the provider's full charges. It is our understanding that these claims cannot be submitted to Medicare by the Retiree or the provider. In such cases, the Claims Administrator will pay based on the MBP's Allowable Expense and no COB would occur. These claims would be paid in the same way as for other Participants.

5.3 Subrogation

In order to prevent the Plan from covering charges that are the legal responsibility of another person or organization, the Employer reserves the right to recover, through its Claims Administrator, Benefit expenses paid by the Plan for an illness or injury that is covered by a third-party liability insurance policy for which another person or organization is liable.

If a Participant or a Dependent is injured or becomes ill by the actions of another person or organization, and the Plan covers charges that are the legal responsibility of that other person or organization, the Claims Administrator will undertake to recover any amounts paid by the Plan in relation to the injury.

If a Participant submits a Claim for Benefits under the Plan in connection with an illness or injury for which another person or organization is liable or potentially liable, it is the Participant's obligation to notify the Claims Administrator of this fact immediately. In order for the Claims Administrator to initiate recovery of Benefits paid, the Participant or Dependent must provide details concerning the time, location, and persons involved in the incident, as well as information concerning any insurance plans that will cover the injury or need for care.

The Participant and Dependent will be required to execute and deliver all documentation and information and do whatever else is necessary to secure the Employer's rights to be subrogated.

ARTICLE VI

CONTRIBUTIONS AND FUNDING

6.1 Contributions

A. **General.** The Employer and, in most cases, Participants contribute toward the cost of Coverage under the Plan with the Employer contributing three fourths of the Plan's total income and Participants contributing one-fourth. In the aggregate, contributions are based on Claims experience and administrative expenses. The Employer is responsible annually for determining contribution rates on the basis of Claims experience and negotiating administrative expenses with the Claims Administrator, Case Management Reviewer, and other service providers. Individual Participant contributions are based on the Participant's net salary or gross pension depending on whether the Participant is an Employee, Retiree, Disabled Person, or Survivor. In the case of a Qualified Beneficiary or Other Dependent, the contribution rate is based solely on the experience of the entire group of Participants and Dependents.

Currently, Participant contributions for single Coverage equal approximately 1.9 percent of income, i.e., net salaries or gross pensions. Contributions for the other enrollment categories are related to the cost of single Coverage in accordance with the ratios indicated below. The basic structure of the contribution schedule is reviewed periodically in light of the Plan's actual Claims experience, which may result in a change in the contribution rate or in the relative contributions for the different categories of enrollment.

Enrollment Category	Relative Contribution Ratios
Single Coverage	1.00
Married couple Coverage	2.00
One-parent family Coverage	1.75
Two-parent family Coverage	2.50

Other Dependent Coverage, Coverage for Participants and Qualified Beneficiaries electing the extension option and Coverage for Participants on leave without pay for personal reasons is unsubsidized, i.e., the Participant pays the full cost of the Coverage.

The financial experience of the Plan is reviewed at least once each year after the end of each Plan Year, and, if there is a net surplus of income over expenditures (including

provision for a reserve), there may be a return of contributions to the Employer and Participants in accordance with the cost-sharing ratio of 3:1. If the Plan is in deficit and projections indicate that future income will not be sufficient to meet expenses, changes in the contribution structure or in Benefits may have to be introduced.

The Employer reserves the right to change the cost-sharing ratio between the Employer and Participants; to set monthly Participant contributions at a level that will, taken together with the Employer's contribution, cover the costs of financing the Plan; and to make other changes to the contribution schedule that are deemed necessary.

B. **Contribution schedule.** Participants pay for their Coverage in accordance with a fixed schedule of monthly contributions based on 15 income level steps and enrollment category (e.g., single or two-parent family). The lowest contribution step is for Participants with annual incomes of less than the minimum salary of Grade A1. The highest contribution step is tied to the minimum of the salary range for Grade A14. The13 steps in between cover income ranges approximately corresponding to the range between the minimum salaries of each adjacent grade from Grade A1 to Grade A14. This approach allows for the automatic adjustment of the contributions and prevents an increase in the number of steps.

C. **Basis for Subsidized Contribution Rates.** The Employer subsidizes the contributions paid by (a) Participants in pay status, (b) Participants on leave without pay in the interest of the Fund, (c) Participants who are Retirees or Disabled Persons, and (d) Participants who are IMF Institute Participants. The same levels of contribution apply to those enrolled with limited or full Coverage.

1. Participants in pay status (e.g., Employees and Employees on external assignment programs in pay status as those set forth in GAO. No. 7, as it may be revised from time to time). Contributions by Participants in pay status are based on the schedule of net salaries described above.

2. **Participants on leave without pay in the interest of the Fund as set forth in GAO No. 13,** as it may be revised from time to time**.** For Participants on leave without pay in the interest of the Fund, the income level on which contributions during the period of such leave are based is the net annual Fund salary in effect immediately prior to the start of the leave; contributions are affected by general salary adjustments that may occur during the period of absence. Participants going on leave without pay must pay their contributions in accordance with a schedule approved by the Fund and provided by the Claims Administrator.

3. **Participants who are Disabled Persons.** Contributions of Disabled Persons are based on the gross annual pension from the Employer.

4. **Participants who are Retirees.** Contributions in retirement are based either on the Participant's gross annual pension from the Employer or on final net salary. A Participant retiring who elects to commute a portion of his pension pays contributions based on the unreduced pension that he would have been entitled to had he not commuted. This applies to persons retiring at the normal retirement age of 62 (or later), as well as to those taking early retirement, who are eligible to continue Coverage after five years of Participation in the Plan. Contributions for an individual who participates in the MBP as a contractual employee following employment as a staff member shall be determined in accordance with the provisions of the Plan governing either (a) a Retiree, who has previously met the eligibility requirements of the Plan, or (b) for a period of 18 months following separation from the staff, a Participant with continuing coverage under the extension option of the Plan.

The Plan's cost-sharing formula provides for Participants to pay 25 percent of the total premium cost and the Fund to pay 75 percent. There is no change to this formula for Retirees with 10 or more years of Plan participation. However, the contribution ratio for Retirees who separate with less than 10 years of preretirement Plan participation is computed in accordance with the graduated scale and computation base set out below. The scaling ratio for Plan participation of five years or less starts at 50/50 (Employer/Retiree) increasing to a maximum of 75/25 (Employer/Retiree) after 10 years of pre- and post-retirement Plan participation. The applicable cost-sharing factor and contribution rate for Retirees with less than 10 years of Plan participation will be based upon the number of completed years of Plan Participation as of May 1 of each year. This provision applies to former Employees who were covered under the post-employment Extension Option as of January 1, 2002 and who met the eligibility rules on separation age and Plan participation. The 18-month post-employment Continuation Period counts toward the minimum participation requirement for eligibility and in determining the computation base.

Years of Plan Participation	Contribution Percentage	
	Fund	Staff
10+ years	75.0	25.0
9–10 years	70.0	30.0
8–9 years	65.0	35.0
7–8 years	60.0	40.0
6–7 years	55.0	45.0
5–6 years	50.0	50.0
Less than 5 years, age 62+	50.0	50.0

Computation base. Retirees with 10 or more years of pre-retirement Plan participation pay contributions based on their **gross annual pension.** The contribution of Retirees with less than 10 years of Plan participation at the time of retirement will be permanently based on **final net salary**. The salary upon retirement will be adjusted annually in accordance with the increase in the U.S. Consumer Price Index in the same manner as Staff Retirement Plan pensions paid in U.S. dollars.

Persons who were former Employees on or before January 1, 2002, who were eligible to participate in the Fund's Staff Retirement Plan, and who were either already age 62 or older, or who have since separated or will separate after reaching age 62 with less than 10 years of Plan participation, are grandfathered under the 75/25 percent cost-sharing formula based on final net salary.

Persons who were former Employees on or before January 1, 2002, who were eligible to participate in the Fund's Staff Retirement Plan, and who have since separated or will separate after reaching age 55, but before reaching age 62, with at least 10 years of Fund service but less than five years of Plan participation, are grandfathered under the 75/25 percent cost-sharing formula based on gross annual pension, provided they joined the MBP by February 11, 2002.

Incentive for participation in national health scheme. Participants (or their Dependent Spouses or Survivors or Other Dependents) drawing a pension from the Fund's Plan are entitled to receive an incentive relative to their contributions to their national health insurance if they enroll in a national health insurance scheme such as Medicare, Parts A and B. The purpose of the incentive is to encourage participants to obtain coverage under national health insurance schemes to reduce the cost of medical claims paid by the MBP.

5. **Participants who are Survivors**. A Participant who is a Survivor pays contributions based on the annualized amount of the Spouse pension or children's Benefit payable under the Fund's Staff Retirement Plan.

6. **Participants who are IMF Institute Participants.** The IMF Institute pays the 25 percent contribution on behalf of the IMF Institute Participants and the Employer pays the remaining contribution.

D. **Local currency pensions.** A Participant who receives his Employer pension in local currency has his contributions based on the U.S. dollar equivalent of his local currency pension on May 1 of each year.

E. **Basis for Unsubsidized Contribution Rates**. The unsubsidized contribution rates, which can change annually on May 1, are based on the Plan's overall financial experience in the previous Plan Year, and apply regardless of income level. These rates apply to Coverage for Other Dependents, staff on leave without pay for personal reasons and Qualified Beneficiaries under Section 7.9.

F. Adjustments in contributions are published in Employer newsletters, on its intranet and/or by bulletin announcements. Information concerning current contributions is available from the Employee Self-Service kiosk on the Employer's intranet and Human Resource Center.

6.2 First and Last Contributions

Participant contributions required for participation in the Medical Benefits Plan are taken from the first pay period following the effective date of Coverage through the pay period following separation or, the cancellation of Coverage, unless the Participant qualifies for Coverage as a Retiree. The new contribution for an Election to change Coverage becomes effective in the first pay period following the effective date on which the Election is received by the Plan Administrator, or his representative, subject to the review and approval of the Claims Administrator, if applicable. A change in the schedule of contribution rates or, a change in the Participant's salary, which would affect the Participant's contribution for the Coverage, will become effective in the pay period following the effective date of the change in contribution rate or, action date amending the Participant's salary. (Deductions for pensioners are effective the first of each month with the deductions taken at the end of the month).

Retroactive adjustments for either reimbursement to the Participant of overpayments or recovery by the Employer of underpayments are limited to a six month period counted from the date of notification (via receipt of the relevant pay advice) of a change in the amount of the contribution.

6.3 Self-Insured Plan Benefits

Plan Benefits are provided under an administrative services agreement between the Employer and the Claims Administrator. Benefits provided under the administrative services agreement are self-insured by the Employer. The Plan's Claims and the resulting cost as reflected in the contribution rates of the Employer and the Participants may be reduced to the extent that Participants use Providers who participate in a Preferred Provider Organization (PPO).

ARTICLE VII

COVERAGE UNDER CHANGED CIRCUMSTANCES

7.1 Discharge or Voluntary Termination (including Resignation, and Completion of Contractual Employment)

Coverage is continued through the end of the month in which employment terminates.

7.2 Disability Retirement

See Sections 3.5 and 6.1 C 3.

7.3 Separation for Medical Reasons

Where the employment of a Participant terminates upon his exhaustion of sick leave and the Participant does not qualify for a disability pension under the Employer's Staff Retirement Plan, but the Participant is considered unable to work, Coverage for the Participant will continue for the earlier of the duration of the disability or 12 months. In order to obtain this Coverage, acceptable proof of disability must be submitted to the Claims Administrator before the end of the month in which Coverage would normally end. The Claims Administrator is responsible for determining whether the documentation submitted meets the criteria for continued Coverage under this provision. Such Coverage is provided at no cost with respect to the Participant qualifying for such Coverage.

7.4 Reduction in Strength, Abolition of Position or Change in Job Requirements

A. Termination of Coverage. Coverage of Participants who were covered at the time they were affected by a reduction in strength, abolition of position or change in job requirements, as described in General Administrative Order No. 16, as it may be revised from time to time, will continue for the Participants and their Dependents on the same basis as for Employees for the duration of the separation leave. If the Participant accepts a transfer to a position on a temporary basis prior to the separation, Benefits under the Plan associated with the separation leave will not begin until he terminates such temporary employment. If the Participant transfers to a permanent position, Benefits based on the separation leave are not initiated.

B. Return to Work. Covered persons will have continuous Plan Coverage if they return to work prior to the exhaustion of separation leave following the month of employment termination and elect to continue Coverage.

7.5 Retirement

See Sections 3.4 and 6.1 C 4.

7.6 Leave of Absence

If a Participant is on leave without pay for more than 30 consecutive days before having completed one year's Participation Service in the Plan, Coverage will be suspended until the Participant returns to pay status (shorter periods of leave without pay will not result in suspension of Coverage). However, if the Participant has been enrolled for at least one year prior to the date that his leave without pay commences, then Coverage can be treated as follows:

A. Leave Without Pay in the Interest of the Fund. If the Participant's leave without pay is determined to be in the interest of the Fund, Coverage may be continued during the period of such leave, and the Participant's cost of Coverage will be at the subsidized rate. Alternatively, a Participant may suspend enrollment in the Plan until he returns to pay status.

B. Leave Without Pay Not in the Interest of the Fund. If the Participant's leave without pay is not in the interest of the Fund, he may continue Coverage under the Plan for up to 24 months; thereafter, enrollment will be suspended until the Participant returns to pay status. If the Participant elects to continue Coverage, the cost of such Coverage will be at the unsubsidized rate. A Participant also has the option of suspending Coverage under the Plan for the entire period of his leave without pay.

Once a Participant's Coverage is suspended, it may not be reinstated until the Participant returns to pay status.

7.7 Extended Benefit Period for Ongoing Treatment

When Coverage of a Participant (including a divorced Spouse, a Survivor and his Dependents) terminates for any reason, Plan Benefits are payable beyond the date of termination of Coverage if on such date the Participant is under the care of a provider for the treatment of an illness or injury covered by the Plan. Coverage will be provided in the following manner, but only for care associated with that specific illness or injury, according to the terms of the applicable Incorporated Document, and only if approved by the Claims Administrator:

A. In the case of illness that is totally and continuously disabling, Benefits are payable for expenses incurred up to 12 months after the date of termination of Coverage or until recovery from the illness or injury, whichever occurs first.

B. In the case of illness or injury that is not totally and continuously disabling, Benefits are not payable after Coverage terminates.

7.8 Extended Benefit Period for Disabled Dependents

If a Dependent is totally disabled on the date Coverage under the Plan would normally end, Coverage for the affected Dependent will continue for the earlier of the duration of the disability or 12 months. In order to obtain this Coverage, acceptable proof of disability must be submitted to the Claims Administrator before the end of the month in which Coverage would normally end. The Claims Administrator is responsible for determining whether the documentation submitted meets the criteria for continued Coverage under this provision. Such Coverage is provided at no cost with respect to the Dependent qualifying for such Coverage.

7.9 Qualifying Events—Extension Option

If a Participant or Dependent experiences a Qualifying Event and becomes a Qualified Beneficiary, Coverage may be continued if the Participant or Qualified Beneficiary makes an Election to do so and pays the applicable contribution within 60 days following the later of the date that Coverage normally ends or the date on which the Employer or Claims Administrator gives notice of eligibility to continue or extend Coverage.

During a Continuation Period, Coverage may be continued for up to 18 months for all Qualifying Events except in the cases of: (1) a divorce, where Coverage of the former Spouse may be continued for up to 36 months, and (2) Former Employees who separated in the context of the downsizing beginning May 2008, where Coverage may be continued up to 36 months.

The Employer or Claims Administrator will mail enrollment materials to the Qualified Beneficiary. If the enrollment is completed within the 60-day limit described above and the applicable premium is paid, Coverage will be effective immediately upon the termination of the original Coverage. Evidence of good health is not required. Payment of the contribution is due 45 days after enrollment. Payment is due retroactive to the date of the termination of the original Coverage.

The type of Coverage (single, couple, family) can be changed if there is a family status change and the Claims Administrator is notified within 31 days of the event.

Coverage automatically ends 18 or 36 months, whichever applies, following the Qualifying Event. However, Coverage may end sooner if the Qualified Beneficiary cancels Coverage or fails to pay the required premium. Once Coverage ends it cannot be reinstated. The Extension Option is not available to IMF Institute Participants.

7.10 Termination of Dependent Status

Coverage of a Dependent Child ceases on the Dependent Child's 26th birthday. When a Participant divorces, Coverage of his Spouse ceases as of the last day of the month that the divorce becomes legally effective, except as provided in Section 7.9.

7.11 Nonpayment of Contributions

A Participant's Coverage is discontinued as of the end of the month for which he has not paid required contributions.

7.12 Plan Termination

Coverage of all Participants is discontinued as of the end of the month in which the Plan is terminated.

ARTICLE VIII

PLAN ADMINISTRATION

8.1 Plan Administrator

A. **Responsibility of Plan Administrator.** The Plan Administrator is responsible for the administration of the Plan, which includes among other things controlling, operating, managing, and administering the Plan in accordance with its terms.

B. **Authority of the Plan Administrator.** The Plan Administrator has all of the authority that may be necessary or helpful to enable him to discharge his responsibilities with respect to the Plan, including the right: to interpret the Plan (but not to substantively modify or amend the Plan); to determine eligibility for Coverage; to determine eligibility for Benefits; to construe any ambiguous provision of the Plan; to correct any default, to supply any omission; to reconcile any inconsistency; and to decide any and all questions arising in the administration, interpretation and application of the Plan. The decisions of the Plan Administrator and his actions with respect to the Plan are conclusive and binding upon all persons having or claiming any right or interest in or under the Plan.

C. **Delegation of Authority.** The Plan Administrator, who may delegate some or all of his authority under the Plan, has delegated authority to construe the Plan's provisions as to eligibility for participation and Benefits for specific services to the Claims Administrators.

8.2 Confidentiality of Health Claims Data

The respective Claims Administrators are responsible for handling all claims and related health data on a confidential basis. The Employer is not involved in the settlement of disputes on individual claims unless such involvement is requested by a Participant or unless review is sought in accordance with the procedures set forth in the Plan. The Employer obtains statistical information on claims in the aggregate from the Claims Administrators and its health claims database vendor, however, no official of the Employer has access to health information on any individual covered by the Plan unless there is evidence of fraud or such information is necessary for purposes of applying for government-sponsored subsidy payments for which the Plan may be eligible (e.g., Medicare Part D). If the Claims Administrators suspect that a fraudulent claim has been submitted or that a claim is being made on behalf of an individual who is not entitled to Plan benefits, they are obligated to bring the matter to the attention of the Employer. Such cases will be handled on a confidential basis by the Employer.

8.3 Time Limitation on Filing a Claim

Claims must be submitted no later than December 31 of a given Plan Year for expenses incurred in the current or preceding Plan Year. If the Claim is not received by December 31, consideration may still be given if it can be shown that the Claim was submitted as soon as was reasonably possible.

8.4 Claims and Benefit Appeals

All Claims for Benefits under the Plan shall be administered according to the applicable Incorporated Document, i.e., Aetna's Summary Plan Description of the Medical Benefits Plan or Vanbreda International's booklet, Summary of The International Monetary Fund's Medical Benefits Plan for Participants Residing Outside of the United States. Any Claimant whose Claim for Benefits has been denied or deemed denied in whole or in part may appeal that decision pursuant to the procedures set forth in the Complaint and Appeals sections of the above referenced Incorporated Documents.

8.5 Request for Administrative Review

Any Claimant whose appeal pursuant to Section 8.4 has been denied or deemed denied in whole or in part may request in writing a review by the Director of Human Resources, in accordance with GAO No. 31, Rev. 4, Section 6.04. The request must be submitted within 30 days after the response from the Claims Administrator or within 30 days after that appeal is deemed denied.

8.6 Exhaustion of Administrative Remedies

No Benefit will be paid and no denial of a Benefit will be subjected to administrative review under GAO No. 31, Rev. 4, Section 6.04, unless the Claimant first complies fully with the Claims and appeal procedures described in the Incorporated Documents referenced in Section 8.4.

8.7 Payment of Benefits

The following points are applicable to the payment of Benefits under the MBP:

- To receive reimbursement under the Plan, a Participant (or in some cases a Spouse or former Spouse) or Provider with a bona fide assignment from the Participant must submit a Claim for a Benefit to the Claims Administrator.

- Three weeks should be allowed for the processing of Claims. A delay in the processing of a Claim may occur if additional information is needed from the Provider of the Covered Service or if the Claims Administrator has some doubt about

the Coverage of a specific service or treatment, in which case the matter may have to be referred to expert medical or dental advisors for review and/or determination of Coverage.

- The Claims Administrator for United States based Participants (U.S. Claims Administrator) pays all Benefits in U.S. dollars or another currency if the expenses were incurred in another currency. All Plan Benefits incurred in U.S. dollars are payable in U.S. dollars. The Claims Administrator for non-United States based Participants (International Claims Administrator) will pay Benefits incurred in other than U.S. dollars in either U.S. dollars or, to the extent possible, the currency used to pay for Covered Services.

- Unless Benefits have been assigned to a Provider of a Covered Service in accordance with accepted procedures, payments for reimbursement are made out in the name of the Participant. (A Spouse of a Participant not residing with the Participant may file Claims and receive reimbursements directly if authorized by the Participant to do so or if legally separated from the Participant). Benefit payments will be sent to the address indicated on the Claim Administrator's file.

- If expenses are incurred in a currency other than U.S. dollars, Benefits are calculated as follows:

    A. If an exchange rate is not indicated on the Approved Form for the submission of Claims, the International Claims Administrator will calculate the U.S. dollar equivalent on the basis of the United Nations Operational Exchange Rate based on the date of receipt of the claims by the International Claims Administrator. To the extent possible, the Participant will be reimbursed in the currency of his/her country of residence. If the International Claims Administrator cannot make payment in the currency in which the expenses were incurred or if a Participant prefers so, he/she will be reimbursed in U.S. dollars. If the applicable rate on the Claim form is provided with an exchange rate receipt, the International Claims Administrator will use this rate in calculating U.S. dollar Benefits. If an exchange rate receipt is not provided, the International Claims Administrator will use the rate, as indicated above.

    B. The U.S. Claims Administrator will convert Benefits on the basis of the exchange rate without interest adjustments on the date of the bill or absent such date, the date the claim was received by the Claims Administrator. The Internet Web site: www.oanda.com or the Wall Street Journal can be used to identify the exchange rate for the appropriate date.

ARTICLE IX

GENERAL PROVISIONS

9.1 General Information

The Plan Sponsor is the International Monetary Fund, 700 19th Street NW, Washington, DC 20431.

The Plan Administrator is the Director, Human Resources Department, International Monetary Fund.

9.2 Misrepresentations and Fraudulent Claims

A. Participants are obligated to notify the Employer of any changes affecting the eligibility of their family members for Coverage under the Plan. Failure to notify the Employer promptly of any such changes or misrepresentation of any material facts, including, but not limited to, marital or Domestic Partnership status or marital or dependency status of family members, is a serious matter and may be cause for disciplinary action, including forfeiture of eligibility for continued participation in the Plan and/or termination of employment.

B. Submission of fraudulent Claims is a serious matter and is considered grounds for disciplinary action, including forfeiture of eligibility for continued participation in the Plan and/or termination of employment.

9.3 Plan Amendment, Suspension, or Termination

The Employer intends to continue the Plan indefinitely, but it assumes no contractual obligation to do so. The Employer may amend, suspend, or terminate the Plan in whole or in part at any time. The Plan Administrator is authorized to effect changes to the plan document from time to time as deemed appropriate. Benefits under the Plan are subject to change and periodic updating in accordance with health insurance industry guidelines followed by the Administrators. Participants will be notified in advance of any significant change in Plan benefits or financing.

9.4 Governing Principles

The Plan is being administered and governed in accordance with: (1) the principles enumerated in EBAP/67/66, April 6, 1967, and (2) accepted insurance industry and medical, dental and prescription drug practices in the United States.

9.5 Gender and Number

Throughout this Plan, the masculine includes the feminine and the singular includes the plural unless the context requires otherwise.

Compensation and Benefits Policy Division
Human Resources Department
International Monetary Fund