2024 Retiree Enrollment Guide for Intercontinental/NYSE Blue Plan for Medicare-Eligible Members

NYSE
AN ICE EXCHANGE

If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices for your prescription drug coverage. Refer to pages 15-17 to review required legal notices, including the Medicare Part D Notice of Creditable Coverage.

www.icenyseretireebenefitplan.com

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WELCOME TO THE 2024 INTERCONTINENTAL EXCHANGE/NYSE RETIREE U.S. BENEFITS OPEN ENROLLMENT!

Intercontinental Exchange/NYSE ("the Company") is committed to providing you with a competitive benefits program that is affordable for both you and the Company. This Enrollment Guide provides all Medicare-eligible retirees with detailed descriptions of the benefits that may be available to you and your eligible dependents, so you can make the right benefit choices.

Eligible retirees may make changes to or enroll in the Intercontinental Exchange/NYSE Blue Plan for Medicare-Eligible Members (the "Blue Plan") at any time from **November 13, 2023 to November 24, 2023**. Enrollments and/or changes will be effective January 1, 2024. There are no plan changes for 2024. However, below are some important factors to be aware of as you make your enrollment decisions. Coverage information can be found within this Guide, and you can also log into www.icenyseretireebenefitplan.com.

Important Enrollment Factors to Consider:

- Re-enrollment in the Blue Plan **will not** be allowed for any coverage that was terminated on or after December 31, 2014.
- Current eligible or future eligible pre-65 retirees that have never enrolled in any Intercontinental Exchange/NYSE Plan for Medicare-Eligible Members (Blue or White Plans, formerly A and B Plans) can still enroll in the Blue Plan during future open enrollments. But once coverage is dropped, you can never re-enroll.
- Premium payments are due the 1st of the month for which coverage is effective. If premium is not received by the last day of the month, your coverage will be terminated for non-payment and you will not be allowed to re-enroll in the Blue plan.
- Coverage for dependent children will terminate on the last day of the month following their 26th birthday.
- You can enroll or make changes online at www.icenyseretireebenefitplan.com or contact the Retiree Service Center by phone by calling 1-888-788-8626, option 2 and the Retiree Service Center Representative will take your change over the phone.

Eligibility

As a retiree of the Company, you are eligible for retiree benefits for yourself and your eligible dependents.

Your eligible dependents include:

- Your opposite sex or same-sex spouse
- Your opposite sex or same-sex domestic partner
- Your or your domestic partner's children under 26 years of age, regardless of marital or student status.
- Your or your domestic partner's disabled child (regardless of age) who was deemed disabled prior to age 26.

Coverage Levels

When you elect retiree medical and/or retiree dental coverage (if applicable-see Dental Section), you may enroll in one of the following coverage levels:

- Retiree Only,
- Retiree plus Spouse,
- Retiree plus Family

The coverage level you elect for retiree medical and retiree dental (if eligible-see Dental Section) must be the same, unless you elect to waive coverage.

For example, you cannot elect Retiree Only coverage for medical, and Retiree Plus Family coverage for dental. You may waive retiree medical coverage, however, and still enroll for retiree dental coverage (if eligible-see Dental Section). You cannot add any dependents who were not enrolled at the time of retirement or who were dropped after retirement.

Waiving Coverage

If you have always waived coverage in any Intercontinental Exchange/NYSE Plan for Medicare-Eligible Members (Blue or White Plans, formerly A and B Plans), you can continue to do so with no adverse effect on your ability to enroll during future annual enrollments.

However, once you have enrolled in the Blue Plan and your coverage terminates at a later date, for any reason, you and any covered dependents **will not** be allowed to re-enroll in the Blue Plan in the future.

Cost of Coverage

The monthly cost of medical coverage is reflected on the *2024 Rate Chart* included with this Enrollment Guide. Monthly premiums for your coverage must be remitted to Mercer. If you are currently receiving a direct bill from Mercer, the new rate will be reflected on the January billing statement you will receive in early December. If you have signed up for electronic funds transfer (EFT) the new premium for 2024 will be automatically deducted from your account in early January.

OVERVIEW OF THE BLUE PLAN FOR MEDICARE-ELIGIBLE MEMBERS

The Blue Plan for Medicare-Eligible members covers a full range of services through Anthem Blue Cross Blue Shield for medically necessary care, usually at 80% of Reasonable and Customary charges (R&C), once you satisfy an annual deductible.

The individual annual deductible is $500 and the family annual deductible is $1,000.

The amount you pay toward covered services is limited by an annual out-of-pocket maximum of $3,500 individual and $7,000 family. Once you reach the out-of-pocket maximum, eligible benefits are paid at 100% of the R&C charge.

For Claims that includes coinsurance until out of pocket maximum is met.

For example: assume you have a hospital stay that results in a $100,000 charge, and both Medicare and Anthem's rate for this service is $100,000. Medicare's responsibility is 80% of Medicare's rate. The Blue Plan bases its post deductible payment on 80% with a 20% coinsurance until you reach your out of pocket maximum. Due to the size of this claim you reach your out of pocket maximum easily and Anthem pays 100% of its rate after your out of pocket maximum of $3500 is applied to your member responsibility.*

*Anthem and Medicare's rate may vary

For Claims where your out of pocket maximum is already fully met.

For example: assume you have a hospital stay that results in a $100,000 charge, and both Medicare and Anthem's rate for this service is $100,000. Medicare's responsibility is 80% of Medicare's rate. The Blue Plan is covering at 100% coverage of your services because your out of pocket maximum was met on previous claims. Anthem will pay $20,000 or 20% because Medicare will have paid $80,000 or 80% as your primary insurance. Anthem comes to the $20,000 secondary payment by determining what Anthem would have paid had we been the primary carrier then subtracting the other carrier's paid amount.*

*Anthem and Medicare's rate may vary

Coordination with Medicare

You are required to enroll in both Medicare Part A and Part B programs. The Blue Plan provides coverage that is secondary to Medicare. Benefit reimbursement from the plan assumes that you are enrolled in the Medicare Part B program.

NOTE: In order to be eligible for benefits under this Plan, you must use a provider that accepts Medicare.

The Plan will coordinate benefits with Medicare under a provision, called non-duplication of benefits. The Blue Plan will base the amount it pays for a covered treatment or service on the amount it would have paid if it were your only coverage. If that amount is equal to or less than the amount Medicare pays as the primary plan, the Blue Plan will not pay benefits because it will assume you have already received coverage under the primary plan. Non-duplication rules exist in most organizations today and are designed to help organizations control costs.

For example: assume you have a hospital stay that results in a $1,000 charge, and Medicare pays $600 of that charge. The Blue Plan bases its payment on the 80% coinsurance, determines that the covered amount would be $800 and pays the additional $200 that Medicare did not cover. Had Medicare paid $800, no further benefits would have been paid by the Blue Plan.

If you are eligible for Medicare and your spouse is not age 65, he or she is eligible for coverage through the Intercontinental Exchange/NYSE Pre-65 Retiree Medical Plans, until he/she becomes eligible for Medicare.

It is ***not*** necessary for you to enroll in a Medicare Part D Prescription Plan since the prescription drug coverage provided to you in the Blue Plan is as good as or better than Medicare Part D plans offered. **If you do elect Medicare Part D coverage, you are no longer eligible for the Blue Plan.**

If your current or future coverage under the Blue Plan is terminated for any reason, you will not be allowed to re-enroll in the Blue Plan in the future. In addition, if the retiree's coverage is terminated, all dependent coverage is also terminated at that time.

MEDICAL BENEFITS AT A GLANCE

Plan Feature	Coverage
Deductible	You must satisfy a plan deductible of $500 individual/ $1,000 family before receiving plan benefits.
Out-of-Pocket Maximum	$3,500 individual and $7,000 family, including your deductible
Lifetime Maximum	Unlimited
Doctors' Office Visits	Covered at 80% after deductible
Routine Exams, including: Physicals, annual routine GYN exam and Pap test, flu shots, PSA screen, immunizations, mammogram	Covered at 80% after deductible
X-ray and Lab Tests	Covered at 80% after deductible
Hospital Care	Covered at 80% after deductible
Emergency Care	Covered at 80% after deductible
Surgery	Covered at 80% after deductible
Durable Medical Equipment	Covered at 80% after deductible
Physical, Speech, Occupational, and Respiratory Therapies 45 visits per therapy per calendar year (not combined with any other therapy)	Covered at 80% after deductible
Chiropractic Care 30 visits per calendar year	Covered at 80% after deductible
Behavioral Health – Inpatient Limited to 100 days per calendar year	Covered at 80% after deductible (coinsurance is excluded from out of pocket maximum)
Alcohol/Substance Abuse – Inpatient Limited to 7 days for detoxification and 100 days for rehabilitation per admission	Covered at 80% after deductible (coinsurance is excluded from out of pocket maximum)
Behavioral Health – Outpatient Limited to 100 visits per calendar year	Covered at 80% after deductible (coinsurance is excluded from out of pocket maximum)
Alcohol/Substance Abuse - Outpatient Limited to 100 visits per calendar year	Covered at 80% after deductible (coinsurance is excluded from out of pocket maximum)
Skilled Nursing Facility Limited to 120 days per calendar year	Covered at 80% after deductible
Hospice Care Limited to 210 days per lifetime	Covered at 80% after deductible
Vision Care	Routine vision care is not covered
Hearing Aids	Not covered
Home Health Care Limited to 120 days per calendar year	Covered at 80% after deductible
All other covered Medical Expenses	Covered at 80% after deductible

Anthem BlueCross BlueShield LiveHealth ONLINE

LiveHealth Online uses two-way video to connect you with US board-certified doctors over the Internet in most states. Doctors are available seven days a week, 24 hours a day. You don't need to schedule an appointment. You don't even have to leave your home or office. Plus, you can see a doctor on the go, right from your mobile device. Doctors can answer your questions, make a diagnosis, and even prescribe basic medications in most states.

The $55 cost is applied toward your deductible. The consultation cost is lower than most urgent care or doctor office visit charges.

To learn more about the LiveHealth service, including whether doctors are available in your state and whether they can provide prescriptions, visit www.livehealthonline.com.

Be sure to read the state limitations before accessing a doctor online. Some state regulations do not allow e-prescribing or tele-health services.

PRESCRIPTION DRUG BENEFITS

You are automatically enrolled in prescription drug coverage when you enroll in retiree medical coverage. New enrollees will receive a separate ID card from OptumRx, the Prescription Drug vendor. OptumRx's network of pharmacies include most major pharmacy, discount, and grocery chains.

The cost of your prescription will depend on the type of drug you choose (generic, brand-name, preferred brand-name), and whether you fill it at an in-network retail pharmacy or through mail-order.

You may visit www.optumrx.com to see which brand-name medications are on the formulary, find a network retail pharmacy or compare medications to find the most cost- effective therapy for your condition.

Prescription Drug Benefits at a Glance

You pay a percentage of the full cost of each retail prescription drug, subject to the minimums and maximums shown below, with no deductible. You pay a copay for mail order prescriptions. Once any one individual has paid $1,500 in prescription costs in a plan year, all future approved prescriptions will be 100% covered for the remainder of the year.

How the Mail-Order Plan Works

This feature provides home delivery (via U.S. Mail) of up to a 90-day supply of prescriptions for one copay.

- The OptumRX CVS90 Saver Plus program allows you to get a 90-day supply of your maintenance medication delivered to your home. **You can also get 90-day refills through the program at a retail CVS pharmacy, instead of your home mail—the choice is yours!**
  - You pay less when you order maintenance drugs through the program.
  - Your pharmacy benefit only covers a limited number of 31-day refills for maintenance medications—after two 31-day fills, you must utilize the CVS90 Saver Plus program.

PRESCRIPTION DRUG BENEFITS AT A GLANCE

	In-Network Retail Pharmacy (31 day supply)	Mail Order (90 day supply)
Generic	20% with a $10 minimum or $30 maximum per each prescription drug	$25 copay
Brand Name Formulary Drugs	20% with a $25 minimum or $75 maximum per each prescription drug	$65 copay
Brand Name Non-Formulary Drugs	40% with a $40 minimum or $120 maximum per each prescription drug	$100 copay

*A Brand-Name Drug Penalty will apply if a prescription is filled for a brand-name drug when a generic equivalent is available. You will pay your portion of the prescription coinsurance, plus the difference between the brand and generic medication costs. To avoid this penalty, your doctor must contact OptumRX to request a medical necessity/authorization. Your doctor indicating DAW on your prescription will no longer avoid this penalty.

HEALTH ADVOCATE

Covered retirees and their families have access to Health Advocate, a unique service provided by an independent company that can help you and your family members handle medical claims issues more quickly and easily.

Health Advocate can help explain the terminology and answer questions about your health benefits, your coinsurance and deductible. They also offer information based on your individual healthcare needs. Health Advocate's team is staffed with experts with many years of experience working with health and benefits questions and issues. Personal Health Advocates are trained professionals —typically registered nurses supported by medical directors and benefits specialists.

Health Advocate provides help and assistance across virtually all healthcare and insurance related issues—medical, dental, pharmacy and related healthcare needs. The following is a brief summary of the types of support our members and their families can receive.

- *Clinical Services*: Get help finding physicians, hospitals and other health care providers; locate Centers of Excellence; schedule appointments; and help coordinate medical needs.

- *Administrative Services*: Get assistance with claims and billing issues, fee negotiations, coverage and benefit issues.

- *Health Coaching*: Prepare members for their physician visits and help them better understand their chronic conditions so they become active participants in the management of their health.

- *Information and Service Support*: Find information and resources, for example, available senior care and treatment options.

Contact Health Advocate directly at (866) 695-8622 or visit www.healthadvocate.com for additional information or response@healthadvocate.com

Health Advocate is not affiliated with any insurance or third party provider. Health Advocate does not replace health insurance coverage, provide medical care or recommend treatment.

DENTAL PLAN

Please note if you were not offered retiree dental at the time that you retired, you are not eligible for this benefit.

The Company offers a dental plan administered by MetLife.

The coverage level you elect for dental must match the coverage level you elected for medical. If you waive or drop medical coverage, you may still enroll in dental coverage, if you are eligible.

How the Dental Plan Works

The Company offers a preferred dental program (PDP) through MetLife. You can go to any dentist when you need care, but you save money when you use a MetLife PDP Network dentist, which can be located at www.MetLife.com/dental. Network dentists have agreed to accept discounted fees for services, thereby increasing your available benefit dollars, and you can only be billed your share of the discounted fee, as shown in the chart on next page.

Dental care is subject to reasonable and customary (R&C) charges based on the zip code where the provider is located.

The plan will pay 100% for preventive care, which includes routine cleanings and check-ups twice a year. For all other services, you must first meet the deductible before the plan pays benefits.

You will not receive an ID card from MetLife and should bring a MetLife Dental Care Claim Form with you when you go to your dentist. You can request a claim form by contacting MetLife at 800-942-0854 or going to www.icenyseretireebenefitplan.com.

Cost of Coverage

The monthly cost of dental coverage is reflected in your annual enrollment letter. You must remit payment to Mercer. If you are currently receiving a direct bill from Mercer, the new rate will be reflected on the January billing statement you will receive in early December. If you have signed up for electronic funds transfer (EFT) the new premium for 2024 will be automatically deducted from your account in early January.

DENTAL BENEFITS AT A GLANCE

	In-Network	Out-of-Netwok
Deductible (does not apply to preventive care and simple fillings)	$50 individual	$150 family
Calendar Year Maximum (per person) Excludes orthodontia	$2,000	$2,000
Preventive Care (cleanings, X-rays, simple fillings)	100%; no deductible	100% of R&C; no deductible
Basic Services including: Root canals, Oral surgery, Extractions	80% after deductible	80% of R&C after deductible
Major Services including: Caps, Dentures, Crowns (caps), Periodontal Treatment	50% after deductible	50% of R&C after deductible
Orthodontia $1,500 lifetime maximum per patient (combined in- and out-of-network)	50% of R&C after deductible	50% of R&C after deductible

You may register at the MetLife website **www.metlife.com/mybenefits** to review your personal claims information, check on claims status, or review the MetLife provider listing. You can also check the availability of network dentists within your area online at www.metlife.com/dental or by calling 1-800-942-0854. A list of network providers in your area will be mailed to you.

VISION COVERAGE

Please note if you were not offered retiree vision at the time that you retired, you are not eligible for this benefit.

The Company offers vision care through EyeMed.

You may enroll in vision coverage even if you waive medical coverage. If you elect medical coverage, the coverage level you elect for vision must match the coverage level you elected for medical.

Cost of Coverage

If you are eligible for this benefit, The Company pays full cost of coverage.

How the Vision Plan Works

The vision plan will be offered through EyeMed. The plan covers routine eye exams as well as prescription eyeglasses (lenses and frames) and contact lenses once every 12 months. You can see any provider you choose, but you'll pay less when you use a provider in the EyeMed network, which can be accessed at www.eyemedvisioncare.com.

VISION BENEFITS AT A GLANCE

Features	Member Cost In-Network	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	$10 Copay	$30
Retinal Imaging Benefit	N/A	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames:		
Any available frame at provider location	$0 Copay; $250 Allowance, 20% off balance over $250	$125
Standard Plastic Lenses		
Single Vision	$10 Copay	$30
Bifocal	$10 Copay	$50
Trifocal	$10 Copay	$70
Lenticular	$10 Copay	$70
Standard Progressive Lens	$10 Copay	$77
Premium Progressive Lens	$10 Copay, 80% of Charge less $120 Allowance	$77
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate – Adults	$25 Copay	$11
Standard Polycarbonate – Kids under 19	$25 Copay	$11
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes material only)*		
Conventional	$0 Copay; $155 allowance, 15% off balance over $155	$125
Disposable	$0 Copay; $155 allowance, plus balance over $155	$125
Medically Necessary	$0 Copay, Paid-in-Full	$200
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used	N/A
Frequency:		
Examination	Once every 12 months	
Lenses	Once every 12 months	
Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

What You Need to Do

- Review this Program Overview that describes your medical benefits in more detail. ***Please note, if you were not offered retiree dental or vision coverage at the time of your retirement, you are not eligible for coverage.***
- Decide if you want to continue with medical and prescription drug coverage and whether you want to make changes to your dental or vision coverage (if you are eligible). ***Keep in mind, if you drop coverage for yourself and/or for a dependent re-enrollment in the Blue Plan will not be allowed in the future.***

If you do not make an active election, you will automatically be enrolled in the Blue Plan, and your 2023 dental and vision coverage will carryover into 2024 at the new rates.

If you want to make changes, please contact:

Intercontinental Exchange/NYSE Retiree Benefit Plan Service Center
P.O. Box 14464
Des Moines, IA 50306-3464
1-888-788-8626, Option 2

Or go online at:
www.icenyseretireebenefitplan.com

LEGAL NOTICES

As a Company retiree covered under one of our retiree medical options, you and your covered dependents have certain legal rights when receiving medical coverage. The Company is required to communicate these rights to you annually.

Women's Health and Cancer Rights Act

If you are receiving benefits under one of the retiree medical options in connection with a mastectomy and you elect breast reconstruction, coverage will be provided. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefit coverage may be subject to any deductibles, copayments, and coinsurance limitations applicable to your medical insurance coverage.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Blue Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice from Intercontinental Exchange/NYSE about Your Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Blue Plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2024. This is known as "creditable coverage".

Why this is important

If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2024 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Notice of Creditable Coverage

Please read this notice carefully. It has information about prescription drug coverage with the Company and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium. Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period. If you are covered by the Company's medical plan, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2024. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are, or become eligible for, Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Intercontinental Exchange/NYSE coverage, Medicare will be your only payer.

You should know that if you waive or drop the Company coverage, and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if the Company coverage changes, or upon your request.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You Handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, assistance in paying for a Medicare prescription drug plan is available. Additional information is available from the Social Security Administration (SSA) at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount. For more information about this notice or your prescription drug coverage, contact the Intercontinental Exchange/NYSE Retiree Benefit Plan (Mercer) Service Center at 1-888-788-8626, option 2 or visit www.icenyseretireebenefitplan.com.

Some Important Things to Keep in Mind

This Enrollment Guide highlights features of the Intercontinental Exchange/NYSE retiree benefits program. If any conflicts arise between the contents of this Guide and any Plan provisions, the terms of the actual Plan documents will govern, in all cases. Intercontinental Exchange/NYSE reserves the right to change, modify or terminate the Plan, or any portion of the Plan, at any time, including the right to require, or increase contributions from retirees in order to continue any or all of the benefits described in this overview. The benefits are subject to the terms and conditions of the benefit plan covering the respective benefit and are subject to change from time to time, and are subject, possibly, to termination.

CONTACT PAGE

Medical	Anthem Blue Cross Blue Shield **1-800-875-9417** www.anthem.com
Prescription Drug Plan	OptumRx (Formerly Catamaran) **1-855-312-7412** www.optumrx.com
Health Advocate	Health Advocate **1-866-695-8622** www.healthadvocate.com email: response@healthadvocate.com
Dental	MetLife **1-800-942-0854** www.metlife.com/dental
Vision	EyeMed **1-800-942-0854** www.eyemedvisioncare.com
Intercontinental Exchange/NYSE Retiree Benefit Plan Service Center	Mercer Retiree Service **1-888-788-8626, Option 2** P.O. Box 14464 Des Moines, IA 50306-3464 www.icenyseretireebenefitplan.com

This booklet is for your information only and is not a legal document. If there is any difference between the information here and the legal documents on which the plans are based, the documents on which the plan is based must govern.


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