2024 Intercontinental Exchange/NYSE Enrollment Guide for Pre-65 Retirees

NYSE
AN ICE EXCHANGE

If you or your covered family member becomes eligible for Medicare while under age 65, please contact the **Retiree Service Center at: 1-888-788-8626**, option 2 to notify us of the effective date of Medicare. Becoming eligible for Medicare may provide more choices for your prescription drug coverage.

Refer to pages 19-20 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 for pre-65 retirees provides you 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 Health Plan ("the Plan") at any time from **November 13, 2023 though November 24, 2023** Enrollments and/or changes will be effective January 1, 2024.

Important Enrollment Factors to Consider:

- Re-enrollment in the 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 the Plan can still enroll 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 that month, your coverage will be terminated for non-payment and you will not be allowed to re-enroll in the 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 eligible-see Dental Section), you may enroll in one of the following coverage levels:

- Retiree Only,
- Retiree Plus Spouse,
- Retiree Plus Child(ren), or
- 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 in 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.

Cost of Coverage

The amount you pay for coverage is shown in the enclosed *2024 Enrollment Rate Chart* (if applicable) included with this Enrollment Guide. Monthly premiums (if applicable) for your coverage must be remitted to Mercer Retiree Service, P.O. Box 14464, Des Moines, IA 50306-3464

Waiving Coverage

If you have always waived coverage (never enrolled) in the Plan, 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 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 plan in the future.

MEDICAL PLAN - RETIREES UNDER 65 (NOT MEDICARE-ELIGIBLE)

You have the choice of two medical options, administered by Anthem Blue Cross and Blue Shield.

- Preferred Provider Organization (PPO)
- High Deductible Health Plan (HDHP)

You are automatically enrolled in prescription drug coverage when you enroll in any of these options.

How the Retiree Medical Options Compare

PPO	HDHP with HSA
✓ Higher premium contributions	✓ Lower premium contributions
✓ Lower annual deductible than HDHP	✓ Higher annual deductible
✓ Covers in-network preventive care 100%services at 100%	✓ Covers preventive care services at 100% in-network
✓ You pay copays with no deductible for office visits and urgent care. In-network care is covered at 90% and out-of-network care is covered at 70% of Anthem's Maximum Allowed Amount	✓ In-network care is covered at 80% and out-of-network care is covered at 60% of Anthem's Maximum Allowed Amount"
	✓ Annual deductible must be satisfied before your prescriptions are covered
	✓ You can use a Health Savings Account (HSA) to pay for current or future eligible healthcare expenses.
	✓ You cannot make or receive HSA contributions if you are covered by another medical plan, unless it meets the IRS definition of permissible other coverage

Preventive Care Benefits

Preventive treatment can help you avoid many life-threatening illnesses, including high blood pressure, diabetes, high cholesterol and even asthma. Additionally, properly scheduled screening tests may help identify medical issues early. In order to encourage proper screenings and preventive care, both medical options cover the following preventive care benefits at 100% in-network, with no out-of- pocket cost to you:

- Annual physical examination
- Annual prostate specific antigen (PSA) screening for men
- Necessary immunization and booster shots
- For a female of any age, annual pelvic exam and Pap test
- For females age 35 and older, annual mammogram
- Routine colon cancer screenings starting at age 50
- Colonoscopy cancer screenings starting at age 50
- Diagnostic x-rays and routine lab tests
- Bone density scans starting at age 55

PRE-CERTIFICATION SERVICES

Certain services, such as inpatient or out-patient hospital procedures require pre-certification before the Plan will pay benefits. This process evaluates the medical necessity of your care and the resources needed to treat your condition.

If you fail to obtain the necessary pre-certification, penalties or claim denial may apply. Call Anthem at 800-875-9417 (PPO) or 800-875-6214 (HDHP) to learn if a future scheduled procedure should be pre-certified. Emergency hospital treatment or admissions should be called in for certification within 48 hours or the next business day. While your provider may assist you, you are responsible for pre-certifying.

The Preferred Provider Organization (PPO) Option

The PPO option allows you to visit any doctor, hospital or other provider. However, you will save money and receive a higher level of benefits when you use network providers.

Receiving Care

In-network doctor office visits are covered at 100% after you pay a co-payment of $25 for primary care and $40 for a specialist. For most other services, you must first satisfy an annual deductible before the plan begins to pay benefits. Once you reach the deductible, you will be responsible for a percentage of the eligible charges; this is coinsurance. To limit your risk, there is an out-of- pocket maximum on the amount you pay each year.

Save Money With Network Providers

No matter which medical option you choose, you will receive the highest level of benefits when you use in-network providers.

The Anthem networks are the same regardless of which medical plan you choose. To find out if your doctor is in the Anthem network, visit www.anthem.com. Under Useful Tools on the right, visit www.anthem.com and click "Find a Doctor". Network discounts are based on where the member lives, regardless of the location of the provider.

- If you live in NY: select **NY as the state. Then to select a plan/network, click Empire POS (Select Network) from the Medical (Employer Sponsored) list. Alternate Network** for *Plan Type* and **Empire POS** for *Plan Name*.
- If you live in GA: select **Georgia as the state. Then to select a plan/network, click Blue Open Access POS (Select Network) from the Medical (Employer Sponsored) list.**
- If you live in any other U.S. location: select **your state of residence, then select a plan/network, click National PPO (BlueCard PPO)**

To find a provider in the Anthem network, visit **www.anthem.com and click on Find a Provider** or call 800-875-9417.

PPO BENEFITS AT A GLANCE – HIGHLIGHTS OF BENEFITS

Feature	PPO	
	In-Network	**Out-of-Network**
Annual Deductible*	$500 individual $1,500 ind+1 /family	$1,000 individual $3,000 ind+1 /family
Out-of-Pocket Maximum* (includes co-pays deductible)	$1,500 individual $4,500 ind+1 /family	$4,500 individual $13,500 ind+1 /family
Lifetime Maximum	Unlimited	Unlimited
Doctors' Office Visits **Primary Care Specialist**	$25 copay $40 copay	Covered at 70% after deductible Covered at 70% after deductible
Emergency Room	$150 copay, then 90% after deductible	$150 copay, then 90% after deductible

* Annual deductible and annual out-of-pocket maximums do NOT cross-apply between in-network and out-of-network.
Out-of-network claims are subject to Anthem's Maximum Allowed Amount. Charges in excess of Anthem's Maximum Allowed Amount are not applied to the out-of-network deductible or the out-of-network out-of-pocket maximum. You are responsible for these charges.

PPO BENEFITS AT A GLANCE CONTINUED

Feature	PPO	
	In-Network	Out-of-Network
Preventive Care: Annual physicals, routine GYN exam/Pap, flu shots, PSA screening, immunizations, mammogram	Covered at 100%; no deductible	Covered at 70% after deductible
Urgent Care	$40 copay	Covered at 70% after deductible
Physical, Speech, Occupational Therapies 45 visits per calendar year (per therapy type) Combined in-network and out-of-network	$40 copay	Covered at 70% after deductible
Chiropractic 30 visits per calendar year Combined in-network and out-of-network	$40 copay	Covered at 70% after deductible
All other covered Medical Expenses	Covered at 90% after deductible	Covered at 70% after deductible

The benefits at a glance is not an all inclusive list of covered or excluded benefits. Please refer to the Summary Plan Description (SPD) for benefit information. If there are conflicts between this list and the SPD, the SPD governs.

The High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

The HDHP is designed to reward you for leading a healthy lifestyle and for making cost-effective choices when you do need care. The plan offers lower premiums in exchange for a higher deductible. It works in tandem with a Health Savings Account (HSA) that allows you to pay for your medical expenses, including your deductible and coinsurance, with tax-free money. With the HDHP, all medical and prescription drug charges, except those for preventive/ routine annual examinations, are subject to the annual deductible before any health care benefits are paid.

You will still have access to the same Anthem network of providers that you would have with the PPO plan.

HDHP BENEFITS AT A GLANCE

Feature	HDHP	
	In-Network	Out-of-Network
Annual Deductible*	$1,600 individual/ $3,200 individual + 1 / family	$3,200 individual/ $6,400 individual + 1 / family
Coinsurance (amount Plan pays after deductible is met)	Covered at 80%	Covered at 60%
Preventive Care: Annual physicals, routine GYN exam/Pap, flu shots, PSA screening, immunizations, mammogram	Covered at 100%; no deductible	Covered at 60% after deductible
Doctor Office Visit	Subject to deductible/coinsurance	Subject to deductible/coinsurance
Emergency Room	80% after deductible	80% after deductible
Urgent care	80% after deductible	60% after deductible
Therapy: physical, occupational, and speech	80% after deductible; maximum 45 visits per year for each therapy	60% after deductible; maximum 45 visits per year for each therapy
Chiropractic	80% after deductible; maximum 30 visits per year	60% after deductible; maximum 30 visits per year
Most other covered care	80% after deductible	60% after deductible

* Annual deductible and annual out-of-pocket maximums do NOT cross-apply between in-network and out-of-network.
Out-of-network claims are subject to Anthem's Maximum Allowed Amount. Charges in excess of Anthem's Maximum Allowed Amount are not applied to the out-of-network deductible or the out-of-network out-of-pocket maximum. You are responsible for these charges.

Note that under the HDHP, if you choose Retiree Plus Child(ren) or Retiree Plus Family coverage, the family deductible must be met before the plan will pay for covered services subject to the deductible for any family member. Refer to the Summary Plan Description for benefit details.

You may contribute to an HSA up to the amount allowed by the IRS for 2024:

- Up to $4,150 per year for Retiree Only coverage
- Up to $8,300 per year for Retiree Plus Dependent or Retiree Plus Family coverage
- A "catch-up contribution" of $1,000 in addition to the above limits if you are age 55 or older

You may open an account through Health Equity, the Plan's HSA vendor, or another institution of your choice. All of the money in your HSA belongs to you and HSA funds can be rolled over from year to year. It's up to you to choose whether to use these funds to pay for qualified medical expenses now, or let the money in your account grow to help pay for future qualified expenses.

Benefits of An HSA:

- An HSA offers multiple tax breaks – tax-free contributions, tax-free earnings on accumulated funds and tax-free distributions for qualified expenses which include covered medical plan expenses and prescription drugs. You may deduct the amount of deposits from your income tax return. We suggest discussing these options with your tax advisor.

- You own the HSA – your contributions and earnings, help your account grow over time. The account is yours to keep, even if you switch medical plans at a later date.

- No limits based on income – if you meet the HSA qualifications, you can open an HSA.

Who Can Participate in the HSA?

To be eligible for an HSA, you must meet the following criteria:

- You must be covered by a qualified High Deductible Health Plan (HDHP).
- You can't be covered by another health plan, including Medicare.
- You can't be claimed as a dependent on another individual's tax return.
- You or your spouse or domestic partner cannot participate in any Traditional Health Care Flexible Spending Account (FSA), even under another employer's plan; you can, however, participate in a Limited Purpose FSA.

Note that there are additional IRS regulations regarding HSA contributions. Please consult your tax advisor for additional details. The Health Equity website has much useful information regarding HSAs, and you can open an HSA with HealthEquity. Visit www.healthequity.com or call 1-877-713-7712.

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. Your cost depends on which medical plan you are enrolled in:

- For the PPO Plan, you pay the $25 office visit copay for a consultation.
- For the HDHP, you pay the $55 retail price until you meet your deductible. The consultation cost is lower than most urgent care and 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.

Livongo by Teladoc Health

With Livongo by Teladoc Health, if you or your dependent is a diabetic, you can manage the condition in real-time with a free two-way wireless glucometer that captures data and tracks progress, and allows for communications with a health coach.

The program is free to members and includes free, unlimited test strips with one-touch mobile reordering for supplies. Personalized support and coaching are available for pre-diabetics to reduce risks for type 2 diabetes. Participants also receive assistance with diet, exercise, and stress. For more information, contact Livongo at 800-945-4355, or www.livongo.com.

Your Anthem Nurse

Your Anthem Nurse offers Anthem members free and confidential access to a team of clinicians who provide integrated and customized care. A dedicated nurse is available to help you understand doctor's instructions, coordinate care, or answer health-related questions for you and your family members. Your Anthem Nurse can help you:

- Find the right care professional or service and coordinate personalized care action plans
- Improve your health status through coaching and support
- Manage high-risk conditions before and after a hospital stay
- Make informed decisions about treatment options

Call 877-529-1693 (option 2), Monday-Friday, 8:30 a.m. to 12 a.m. ET, or visit www.anthem.com.

PRESCRIPTION DRUG COVERAGE

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

How Prescription Drug Coverage Works

Your prescription drug coverage varies based on the retiree medical option you choose. 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.

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.

The following chart explains how prescriptions are covered under each of the medical options through Anthem.

PRESCRIPTION DRUG BENEFITS AT A GLANCE

	PPO		HDHP	
	In-Network Retail Pharmacy (31 day supply)	**Mail Order (90 day supply)**	**In-Network Retail Pharmacy (31 day supply)**	**Mail Order (90 day supply)**
Generic	You pay 20% with $10 minimum or $30 maximum	You pay 20% with $25 minimum or $75 minimum	You pay 20% after deductible*	You pay 20% after deductible*
Brand Name Formulary Drugs (Preferred)**	You pay 20% with $25 minimum or $75 maximum	You pay 20% with $65 minimum or $185 maximum	You pay 20% after deductible	You pay 20% after deductible
Brand Name Non-Formulary Drugs (Non-Preferred)**	You pay 40% with $40 minimum or $120 maximum	You pay 40% with $100 minimum $300 maximum	You pay 40% after deductible	You pay 40% after deductible
Annual out-of-pocket maximum	$1,500 retiree only; $3,000 retiree + 1; $4,500 family		Included with Medical	

*Medical Deductible

**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.

Please note certain drugs may be subject to prior authorization and/or quantity limits. For information about specific drugs that you currently take, which brand-name medications are preferred, find a network retail pharmacy or compare medications, visit www.Optum.com or call **1-855-312-7412**.

There may be drug quantity limits for certain medications.
• The plan covers certain Affordable Care Act (ACA) preventive drugs at 100% along with tier 1 and tier 2 diabetic products (HDHP plan diabetic products paid 100% after deductible).
• Specialty medications are only available as a 30-day supply through the specialty drug pharmacy, Briova. These medications require special handling or monitoring and are used to treat complex, chronic, and often costly conditions, such as multiple sclerosis, hepatitis C, hemophilia, autoimmune conditions, and some oncology drugs.
• This program allows members for certain disease categories, such as MS, Transplant, HIV, that have been stable on treatment the option to fill for 90 days. The program also requires new oncology patients with 15 days of medication for 3 months or until they are stable on their treatment to help avoid waste.

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 below.

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.ice/nyseretireebenefitplan.com

DENTAL BENEFITS AT A GLANCE

	In-Network	Out-of-Netwok
Deductible (does not apply to preventive care)	$50 individual $150 family	
Calendar Year Maximum (per person) excludes orthodontia	$2,000 (combined in- and out-of-network)	
Preventive Care (cleanings, X-rays, simple fillings)	Covered at 100%; no deductible	Covered at 100% of R&C; no deductible
Basic Services including: root canals, oral surgery, extractions	Covered at 80% after deductible	Covered at 80% of R&C; after deductible
Major Services including: caps, dentures, crowns (caps), periodontal treatment	Covered at 50% after deductible	Covered at 50% of R&C after deductible
Orthodontia $1,500 lifetime maximum per patient (combined in- and out-of-network)	Covered at 50% of R&C after deductible	Covered at 50% of R&C after deductible

How to Enroll

Please review the information in this Enrollment Guide carefully. We encourage you to share it with your spouse or domestic partner to help you make your final benefit decisions.

If you decide to make a change you can make your selection online at www.icenyseretireebenefitplan.com or by calling 1-888-788-8626, option 2 and the Retiree Service Center Representative will take your change over the phone.

What Happens if You Do Not Make an Election for 2024?

You do NOT need to make an election if you do not want to make changes to your enrollment. If you do not make an active election during Open Enrollment, your 2023 coverage will carry over into 2024 at the new rates.

Your Open Enrollment elections will be effective January 1, 2024.

Medical Plan for Medicare Eligible Members

When you reach age 65 or if you become Medicare eligible under age 65, you will become eligible for medical coverage under the "Blue Plan for Medicare-Eligible Members" ("Blue Plan")

The Blue Plan is also with Anthem and covers most medically necessary care at 80% of Reasonable and Customary charges (R&C), once you satisfy the annual deductible ($500 individual/$1,000 family).

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

Coordination with Medicare

When eligible for Medicare, you are required to enroll in both Medicare Part A and Part B programs. The Blue Plan provides coverage that is paid secondary to Medicare. Medicare is the primary payor, and benefit reimbursement from the Blue 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 Blue 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 (Medicare). 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.

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.

Please Note: If you choose to elect Medicare Part D coverage, you are no longer eligible for the Blue Plan medical and prescription drug coverage.

Cost of Coverage

The monthly costs of medical coverage are reflected in the rate chart included with this Guide.

Some Important Things to Keep in Mind

This Enrollment Guide highlights features of the Intercontinental Exchange/NYSE 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. The Company reserves the right to change, modify or terminate the Plans, or any portion of the Plans, 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 Guide. 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.

LEGAL NOTICES

As an Intercontinental Exchange/NYSE retiree covered under one of our 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 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 Company medical plan is expected to pay out, on average, as much or better than 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 one of the Company's medical plans, you'll be pleased to know that coverage is,on average, 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 the Company coverage, Medicare will be your only payer.

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, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online 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 Intercontinental Exchange/NYSE Retiree Benefit Plan Service Center at 1-888-788-8626, option 2 or visit www.icenyseretireebenefitplan.com.

CONTACT PAGE

Medical	Anthem PPO **1-800-875-9417** www.anthem.com
HSA	Healthy Equity **1-877-713-7712** www.myhealthequity.com
Prescription Drug Plan	OptumRx **1-855-312-7412** www.optum.com
Health Advocate	Health Advocate **1-866-695-8622** www.healthadvocate.com
Dental	MetLife **1-800-942-0854** www.metlife.com/dental
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
Your Anthem Nurse	**877-529-1693, Option 2** www.anthem.com
Livongo by Teladoc Health:	**800-945-4355** www.livongo.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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