Dental MetLife

Member Services/Claims: 800-275-4638
www.metlife.com/dental

	PPO Dental	
Member Responsibility	**In-Network**	**Out-of-Network[1]**
Type A - Preventive	No charge*	No charge*
Type B - Basic Restorative	Ded., then 20%*	Ded., then 20%*
Type C - Major Restorative	Ded., then 50%*	Ded., then 50%*
Type D - Orthodontia (child only)	50% of PDP Fee	50% of PDP Fee
Deductible		
Type A	None	None
Type B and C - Ind/Fam	$50/$150	$50/$150
Type D	None	None
Maximum (per person)		
Type A, B and C	$2,000/year	$1,500/year
Type D	$1,500/lifetime	

* PDP Fee = Preferred Dentist Program Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full.

1 When services are rendered by a non-participating PDP dentist member is also responsible for charges above the PDP Fee schedule.

Life/AD&D MetLife

Member Services/Claims: 800-275-4638
www.metlife.com

Eligibility: Active, full-time employees working at least 20 hours per week
Insurance Amount: 3 times basic annual earnings subject to the maximum benefit of $500,000
Guarantee Issue: $500,000

Short-Term Disability MetLife

Member Services/Claims: 800-275-4638
www.metlife.com

Eligibility: Active, full-time employees working at least 20 hours per week
Insurance Amount: 60% of your predisability earnings subject to the maximum benefit of $1,250 per week
Elimination Period Before Benefits Begin: 0 days accident; 0 days sickness, if hospitalized; 7 days sickness, if not hospitalized
Maximum Benefit Duration: 13 weeks

Long-Term Disability MetLife

Member Services/Claims: 800-275-4638
www.metlife.com

Eligibility: Active, full-time employees working at least 20 hours per week
Insurance Amount: 60% of your predisability earnings subject to the maximum benefit of $10,000 per month
Elimination Period Before Benefits Begin: 90 days
Maximum Benefit Duration: Reducing Benefit Duration (RBD) with Social Security Normal Retirement Age

Supplemental Term Life*

MetLife
Member Services/Claims: 800-275-4638
www.metlife.com

Eligibility: Active, full-time employees working at least 20 hours per week
Employee Insurance Amount: Available in $10,000 increments to the maximum benefit of the lesser of 5 times your basic annual earning or $500,000
Employee Guaranteed Issue: $100,000
Spouse Insurance Amount: Available in $5,000 increments to the maximum benefit of $100,000
Spouse Guaranteed Issue: $25,000
Child(ren) Insurance Amount: Available in flat amount: $1,000, $2,000, $4,000, $5,000 or $10,000

* You must purchase coverage for yourself in order to purchase coverage for your spouse or child(ren).

Additional Benefits

Holidays

Martin Luther King, Jr.'s Birthday
Memorial Day
Independence Day
Labor Day
Thanksgiving Holiday (Thursday and Friday)
December Holiday (December 25th through January 1st)

Vacation

Completed Years of Service	Vacation Allowance
0-1	10 days
1-2	15 days
2-3+	20 days

Vacation days must be approved in advance by the employee's supervisor.

Sick Leave
Accrues in proportional increments throughout the year. 10 days maximum accrual per year.

Waiving IREX Health Care Coverage
A reimbursement of up to $400 per calendar year is offered to employees who show evidence of healthcare coverage.

Flexible Spending Account
Employees are eligible to participate in a FSA which allows you to use pre-tax dollars to pay for qualifying medical costs, dependent care (child and adult) and commuter benefits.

403b Pension Plan TIAA-CREF 1-800-842-2888
Eligible employees may participate in a pre-tax program which is handled through payroll deductions to assist employees in planning for their retirement. Please see Human Resources for details.

Employee Assistance Program 1-800-765-0770
Professional assistance is provided for a wide range of personal matters and is offered for free to employees and dependents.

Pre-Tax Transit/Parking Benefit
Employees are eligible to receive a pre-tax benefit for public transportation to commute to work. **For 2016** $130 max per month for mass transit and $255 per month for parking.

IREX Professional Development Program
IREX recognizes its obligation to its employees to have them develop the skills necessary to be fully competent professionals. The goal of our professional development program is to advance IREX staff technical and managerial knowledge and skills, facilitate professional networking, and support staff growth as leading international development professionals.

Domestic Partner Coverage
Domestic Partners may be eligible for medical coverage subject to meeting certain requirements.

Legal Services Benefit
IREX provides a pre-paid legal benefit, via payroll deduction, which allows employees to receive basic legal services for a monthly fee.

Full Service Fitness Center/Gym Membership
IREX has partnered with a local full-service fitness center/gym for services. IREX employees who wish to enroll have the opportunity to receive up to 50% off of the cost of the monthly membership (subject to change). Participation in the program is via payroll deduction. Please see Human Resources for details.

UnitedHealthcare Global Assistance (formerly Frontier/MEDEX)
ID Number: 360201
Emergency Response Center: Call Collect 1-410-453-6330
https://members.uhcglobal.com

When working or traveling 100 or more miles away from home or outside of your home country IREX eligible travelers can obtain emergency medical, travel, and personal security assistance, 24 hours a day, anywhere in the world.

IREX is an equal opportunity employer and seeks to maintain a safe, healthful and harassment-free and drug-free workplace. IREX is committed to complying with all applicable District of Columbia and federal laws.

IREX benefits are regularly reviewed and may be revised or changed from time to time as IREX deems appropriate and advisable.

This brochure represents a summary of IREX benefits and does not represent a complete description. For additional details, please see the IREX Employee Handbook, the Benefit Plan Descriptions provided by the insurance carriers, or contact the IREX Washington, DC Human Resources Manager.

USI INSURANCE SERVICES
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410-773-4300 | 800-618-2600
www.usi.biz

IREX
Make a Better World

Employee Benefits Summary 2016

This brochure provides a summary of the plans offered and in no way serves as the Summary Plan Description or plan document for the plans. If there are any discrepancies between this brochure and the plan documents, the plan documents will govern. v.11.15

Medical Benefits CareFirst* www.carefirst.com

BlueChoice - Member Services/Claims: 866-520-6099 • BluePreferred - Member Services/Claims: 800-321-3497
CareFirst Pharmacy - Member Services/Claims: 800-241-3371
Davis Vision - Member Services/Claims: 800-783-5602

New for 2016 – Ameritas Voluntary Vision
Plan 1 - Focus® Plan – VSP Choice Network
Plan 2 - ViewPointe® – EyeMed Select Network
See your 2016 enrollment kit for benefits and rates!

(Policy # SH87)	BlueChoice HMO	BlueChoice Opt-Out *Plus Open Access*		BluePreferred	
Member Responsibility	**In-Network Only**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network[1]**
Deductible - Individual/Family	None	None	$300/$600	$250/$500	$500/$1,000
Coinsurance	None	None	20%	None	20%
Out-of-Pocket Limit					
Medical - Individual/Family	$1,300/$2,600	$1,300/$2,600	$2,000/$4,000	$1,500/$3,000	$3,000/$6,000
Prescription Drug - Individual/Family	$4,500/$9,000	$4,500/$9,000	All drug costs are subject to in-network out-of-pocket limit	$4,500/$9,000	All drug costs are subject to in-network out-of-pocket limit
Lifetime Maximum	None	None	None	None	None
Office Visits - Preventive					
Adult Physical Exam	No charge	No charge	Not covered	No charge	Ded., then 20% of AB
Well Child Care (includes exams/immunizations)	No charge	No charge	20% of AB	No charge	Plan pays 100% of AB
Routine GYN Visit	No charge	No charge	Ded., then 20% of AB	No charge	Ded., then 20% of AB
Breast Cancer Screening	No charge	No charge	No charge	No charge	Plan pays 100% of AB
Office Visits - Illness	$30 PCP/$40 Specialist	$10 PCP/$20 Specialist	Ded., then 20% of AB	$10	Ded., then 20% of AB
Imaging (MRA/MRS, MRI, PET & CAT scans)	No charge	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
X-ray and Lab	No charge	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Hospitalization					
Inpatient Facility	$300 per admission	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Outpatient Facility	No charge	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Inpatient Physician	No charge	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Outpatient Physician	$30 PCP/$40 Specialist	$10 PCP/$20 Specialist	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Maternity					
Preventive Prenatal and Postnatal Office Visits	No charge	No charge	Ded., then 20% of AB	No charge	Ded., then 20% of AB
Delivery and Facility Services	$300 per admission	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Emergency Services					
Urgent Care Center	$40	$20	Ded., then 20% of AB	$10	Ded., then 20% of AB
Emergency Room/Facility (copay waived if admitted)	$50	$50	$50	Deductible, plus $50	In-network deductible, then $50
Physical, Speech & Occupational Therapy	$40[2]	$20[2]	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Chiropractic	$40[3]	$20[3]	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Mental Health/Substance Abuse					
Inpatient Facility Services	$300 per admission	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Inpatient Physician Services	No charge	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Outpatient Facility & Physician Services	No charge	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Office Visits	No charge	No charge	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Durable Medical Equipment	25% of AB	25% of AB	Ded., then 20% of AB	No charge after deductible	Ded., then 20% of AB
Prescription Drugs	**Generic/Preferred Brand/Non-Preferred Brand**	**Generic/Preferred Brand/Non-Preferred Brand**		**Generic/Preferred Brand/Non-Preferred Brand**	
Retail - up to 34-day supply	$15/$35/$60	$15/$35/$60	$15/$35/$60	$15/$35/$60	$15/$35/$60
Maintenance - up to 90-day supply Retail or Mail Order	$30/$70/$120	$30/$70/$120	$30/$70/$120	$30/$70/$120	$30/$70/$120
Vision	**Davis Vision**	**Davis Vision**		**Davis Vision**	
Annual Routine Eye Exam	$10	$10	Not covered	$10 at participating vision provider	Plan pays $33, you pay balance
Eyeglasses and Contact Lenses	Discounts from participating vision centers	Discounts from participating vision centers	Not covered	Discounts from participating vision centers	Not covered

*** See UnitedHealthcare Global Assistance (formerly FrontierMEDEX) under the Additional Benefits section, while on overseas business travel.**

AB = Allowed Benefit Ded = Deductible PCP = Primary Care Physician

1 When covered services are rendered by a provider not in the Preferred Provider network, care is reimbursed as Out-of-Network. When services are rendered by Non-Preferred Providers, charges in excess of the Allowed Benefit are the member's responsibility.
2 Limited to 30 outpatient visits per condition per benefit period.
3 Limited to 20 outpatient visits per benefit period.