The IEEE Member Group Vision Insurance Plan

FOR IEEE MEMBERS AND THEIR FAMILIES

IEEE works with the VSP Vision Program, so that you and your family members can choose from one of the largest networks of ophthalmologists, optometrists and opticians in the nation. It's crystal clear: you will have more convenience for routine care and services. The network is so important when choosing a vision benefits plan. It is about more than just size; the plan should include the right mix of vision providers for you and your family.

Eligibility: As a member of IEEE, you and your family are eligible for coverage. Your lawful spouse and dependent children under age 26 are also eligible for coverage. To become insured, an enrollment form must be submitted and the required premium contribution must be paid.

Effective Date: Coverage for you and your eligible dependents will become effective on the first day of the month after your enrollment form has been approved and your first premium is received.

Termination: Your Vision Plan protection will not be canceled due to claims and you cannot be singled out for a rate increase. Your coverage continues as long as you pay your premiums when due, keep your IEEE membership, and the group policy remains in force. Your dependents' coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

With your IEEE-endorsed VSP Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember that your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists, and opticians, from private practices to retailers like Walmart, Sam's Club and Costco.
- Keep in mind, when you visit a VSP Provider, your out-of-pocket expenses are lower and there are no claim forms to complete.

Coordination of Benefits

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

Exclusions and Limitations of Benefits

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

Not Covered

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

VSP CHOICE

Base

Exam Copay (comprehensive exam with dilation)	$15 copay
Materials Copay (Include Lens and Frame)	$25 copay
Retinal Imagining Screening	$39 maximum copay
	$0 Copay for members with diabetes

Benefit Frequency

EYE EXAMINATION: Covered in full* once every **12** months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES:
Covered in full* once every **12** months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular), Standard Progressive Lenses

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Premium and Custom Progressive Lenses, Anti-Reflective Coating, Photochromic: ***Average savings of 30%***

Guaranteed Cost Control Pricing on Lens Enhancement:
Average savings of 30% on ALL LENS enhancement.

Contact Lens Allowance:
$150 towards contacts and contact lens exam (fitting and evaluation)

Necessary Contacts (fitting & evaluation and materials):
Covered in full less material copay

†**FRAMES:**

Frame Allowance:	$150; 20% off overage
Featured Frame Brands Allowance:	$170
Walmart/Sam's Club Allowance:	$150
Costco Allowance	$80

FRAMES - Covered up to the Plan allowance* once every 24 months**

Enhanced

Exam Copay (comprehensive exam with dilation)	$15 copay
Materials Copay (Include Lens and Frame)	$25 copay
Retinal Imagining Screening	$39 maximum copay
	$0 Copay for members with diabetes

Benefit Frequency

EYE EXAMINATION: Covered in full* once every **12** months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES:
Covered in full* once every **12** months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular), Standard Progressive Lenses

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Premium and Custom Progressive Lenses, Anti-Reflective Coating, Photochromic: ***Available under EayOptions upgrade.***

Guaranteed Cost Control Pricing on Lens Enhancement:
Average savings of 30% on ALL LENS enhancement.

Contact Lens Allowance:
$200 towards contacts and contact lens exam (fitting and evaluation)

Necessary Contacts (fitting & evaluation and materials):
Covered in full less material copay

†**FRAMES:**

Frame Allowance:	$200; 20% off overage
Featured Frame Brands Allowance:	$220
Walmart/Sam's Club Allowance:	$200
Costco Allowance	$110

FRAMES - Covered up to the Plan allowance* once every 12 months**

*****EASYOPTIONS UPGRADE: CHOOSE YOUR OPTION**

An Additional $50 Frame Allowance
OR
Progressive Lenses Fully Covered
OR
Light-reactive Lenses Fully Covered
OR
Anti-glare Coating Fully Covered
OR
An Additional $50 Contact Lens Allowance

*Less any applicable Copayment.
**Beginning with the first date of service.

†Only available to VSP members with applicable plan benefits.
Frame brands and promotions are subject to change.

***Coverage with a retail chain may be different or not apply. VSP EasyOptions plan benefits are not available at Walmart, Sam's Club, or Costco.

In the "Enhanced Plan," each member on the plan can choose a covered **EasyOptions Upgrade** after getting a prescription from a VSP network doctor. With **EasyOptions**, each member and covered dependent on the plan gets to choose one covered upgrade that's right for them.

QUESTIONS?

1-800-493-IEEE (4333) **IEEE.service@getamba.com** **IEEEinsurance.com**

ADDITIONAL BENEFITS AND DISCOUNTS

Essential Medical Eye Care:

- Retinal screening for members with diabetes with no copay.
- Additional exams and services beyond routine care to treat, after $20 per exam, immediate issues from pink eye, sudden changes in vision.
- To monitor ongoing conditions, after $20 per exam, such as dry eye, diabetic eye disease, glaucoma and more.
- Additional pairs of Prescriptive Glasses or Non-Prescriptive: $20% off from any VSP doctor within 12 months of your last WellVision Exam.
- Laser Vision Correction: Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.
- TrueHearing offers exclusive discounts on hearing aid and batteries, up to 60% savings.

Please refer to the certificate of coverage to determine available benefits and how to obtain medical plan benefits.

Out-of-Network Allowance for Base and Enhanced Plan

- Exam $45
- Single Vision Lenses $30
- Bifocal Lenses $50
- Trifocal Lenses $65
- Frame $70
- Elective Contact Lenses $105
- Medically Necessary Contact Lenses $210

Monthly Rates

	Base Plan	Enhanced Plan
Member	$12.72	$21.95
Member & 1 Dependent	$22.30	$37.79
Member & Family	$27.75	$47.00

Association Member Benefits Advisors, LLC (AMBA)

IEEE Member Group Insurance Program
P.O. Box 14533
Des Moines, IA 50306

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

QUESTIONS?

1-800-493-IEEE (4333)

IEEE.service@getamba.com

IEEEinsurance.com

THE IEEE MEMBER VISION PLAN ENROLLMENT FORM

TO ENROLL:
Send this completed form with your premium check to:

ADMINISTRATOR
IEEE GROUP INSURANCE PROGRAM
P.O. Box 14533
Des Moines, IA 50306

QUESTIONS?
Call : 1-800-493-IEEE(4333)
E-Mail: ieee.service@getamba.com

Underwritten by: vsp vision care

PLEASE PRINT IN INK OR TYPE - DO NOT USE CORRECTION FLUID OR GEL PEN - INITIAL AND DATE ANY CHANGES

ENROLLEE — Please print or type. Complete all areas, sign and date

Name:_____
Add 1:_____
Add 2:_____
City, St., Zip:_____

Social Security # _____
Date of Birth_____ Sex ☐ M ☐ F
(Mo./Day/Yr.)
Phone Numbers:
(_____) _____
Home
(_____) _____
Work
E-Mail _____
(For internal use only for important announcements, time sensitive bulletins or member notifications. Neither IEEE nor the Plan Administrator will sell or rent your email address under any circumstances.)
Eligibility Date _____
(FOR OFFICE USE ONLY)

MEMBERSHIP AFFILIATION

Are you now a member of The Institute of Electrical and Electronics Engineers, Incorporated?
☐ Yes ☐ No Membership # _____
Membership in **IEEE** is required for participation in the plan. Affiliate members are not eligible.

COVERAGE OPTIONS

Please select the type of coverage you would like. Enclose a check for the rate selected and mail it with this Enrollment Form to Association Member Benefits Advisors, LLC (AMBA). Even if you select Automatic Check Withdrawal, you are required to send a check for your first month's premium along with a blank voided check.

Base Plan	Enhanced Plan
☐ Member Only	☐ Member Only
☐ Member +1 Dependent	☐ Member +1 Dependent
☐ Member + Family	☐ Member + Family

IF APPLYING FOR DEPENDENT COVERAGE (SPOUSE/DOMESTIC PARTNER OR CHILD), COMPLETE THE FOLLOWING:

Number of dependents (including spouse/domestic partner) _____

Name of Spouse/Domestic Partner (Last, First, MI)	Social Security Number	Date of Birth	Sex (M/F)

Name(s) of Child(ren) (Last, First, MI)	Social Security Number	Date of Birth	Sex (M/F)	Is child a full-time student?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

BILLING OPTIONS

Indicate how you wish to be billed:

☐ Automatic Monthly Check Withdrawal

☐ Quarterly Direct Bill

(If you select Automatic Monthly Check Withdrawal, please complete the Automatic Monthly Check Withdrawal request below.)

PLEASE READ AND SIGN

I have read and understand the conditions and exclusions of the program. I hereby enroll in The Group Dental Insurance Plan for IEEE Members. I understand that the plan enrolled for shall become effective on the date specified by the administrator only if this Enrollment Form is accepted and the first payment is paid by the Effective Date. I represent that to the best of my knowledge and belief all statements and answers recorded above are true and complete.

X_____ **X**_____

Member's Signature Date

AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below. Remember to include your first premium and a blank voided check with your application.

Checking Account

Routing #: ___ ___ ___ ___ ___ ___ ___ ___ ___ **Account #:** _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____**Date:**_____

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