City of Carson City
Agenda Report

Date Submitted: 5-12-15

Agenda Date Requested: 5-21-15
Time Requested: 5 minutes

To: Board of Supervisors

From: Melanie Bruketta, HR Director

Subject Title: (For Possible Action) Action to approve the employee vision plan with VSP for a two year period. (Melanie Bruketta)

Staff Summary: This action is to approve the employee vision plan for a two year period with a rate reduction. There are slight changes to the plan.

Type of Action Requested: (check one)

Type of Action Requested: (check one)

(__) Resolution (__) Ordinance

(X)Formal Action/Motion (__) Other (specify)

Does this Action Require a Business Impact Statement: (__)Yes (X) No

Recommended Board Action: I move to approve the employee vision plan with VSP for a two year period. (Melanie Bruketta)

Explanation for Recommended Board Action:

This action is to approve the employee vision plan for a two year period with a rate reduction. There are slight changes to the plan.

City's current plan:

12/12/24 (exam/lenses/frames)
Copay: $25.00 exam & $25.00 materials
Allowances: $140 retail frame or $140 elective contact lenses

Current Rates: $6.36 (ee)/$8.26 (ee plus child(ren))/$9.87 (ee plus spouse)/$15.76 (ee plus family)

New plan:
12/12/24 (exam/lenses/frames)
Copay: $25.00 exam & $25.00 materials
Allowances: $140 retail frame or $140 elective contact lenses

Rates:$6.27 (ee)/$8.14 (ee plus child(ren))/$9.73 (ee plus spouse)/$15.55 (ee plus family)

Applicable Statue, Code, Policy, Rule or Regulation: N/A

Fiscal Impact: $71,879.44/year

Explanation of Impact: Vision insurance premiums will decrease.

Funding Source: Group Medical Insurance Fund

Alternatives: Continue negotiations with VSP

Supporting Material: 2015-2017 Renewal Rates and Renewal Contract (July 1, 2015-June 30, 2017)

Prepared By: Melanie Bruketta, HR Director

Reviewed By: Nick Williams Date: 5/12/15
(City Manager)

Date: 5/12/15
(Finance Director)

Date: 5/12/205
(District Attorney)

Board Action Taken:

Motion(s):_____ 1)_____ Aye/Nays

2)_____ _____

_____

_____

_____

_____

_____
(Vote Recorded By)

April 30, 2015

Ms. Paola Loupe
City of Carson City
201 N Carson St, Ste 4
Carson City, NV 89701-4289

Re: City of Carson City 12072742 / July 1, 2015 Renewal Notification

Dear John:

On March 4, 2013, the IRS published in the Federal Register a rulemaking that will require VSP and others that sell fully-insured vision, dental and medical insurance policies to pay a Health Insurance Provider Fee (HIPF) to the IRS starting in 2014. As you know, City of Carson City fully insures their VSP Program. In order to comply with this federal legislation, your VSP renewal rates include the ACA tax effective July 1, 2015.

Pursuant to section 4.02 of City of Carson City contract with VSP *"...VSP may increase premiums during a Plan Term by the amount of any tax or assessments not now in effect but subsequently levied by any taxing authority, which is attributable to premiums VSP receives from Group."* Please click here for more information on the Federal Register rulemaking.

At VSP Vision Care, we're focused on taking great care of you and your organization. Your satisfaction is our top priority and effective July 1, 2015 your Signature Plan includes the following:

Enhanced Contact Lens Benefit- This benefit design allows members to use their full contact lens allowance toward contact lenses and provides both standard and premium fit contact lens wearers a covered-in-full contact lens exam after a copay that will never exceed $60.

Freedom of Choice- VSP Open Access[SM] provides members the flexibility to use their VSP benefits at any location, including specialty optical boutiques or retail chains. While 95% of our members choose a VSP provider to maximize their benefit, we offer a generous reimbursement schedule for services from all other providers. The new schedule is included in the attached renewal notice.

Diabetic Eyecare Plus Program covers additional services for eligible members with Diabetes Type 1 and Type 2, Age Related Macular Degeneration (AMD), and Glaucoma. There's just a $20 copay with no limit on visits.

To continue VSP's program for this next policy, sign and return the Renewal Agreement by e-mail to: jason.watkins@vsp.com or fax to: 916-463-3926 by June 1, 2015. Please consider VSP your long-term partner in helping you maximize your benefit dollars. To learn more about other plans and ways you can enhance your coverage, please contact your VSP representative, **Jason Watkins at (800) 852-7600 x5555.**

Thank you for choosing VSP.

Cordially,

Jason Watkins
Client Manager

VSP Vision care for life

RENEWAL AGREEMENT

Group Name/Number: **City of Carson City / #12072742**

Current Plan Design Option I

Plan Type:	Signature
Frequency:	12/12/24
Copays:	$25 Exam/$25 Materials
RFA & ECL Allowance:	$140 & 140
Current Rates:	$6.36/8.26/9.87/15.76
Renewal Rates:	$8.21/10.66/12.74/20.35

Alternative Plan Design Option II

Plan Type:	Choice
Frequency:	12/12/24
Copays:	$25 Exam/$25 Materials
RFA & ECL Allowance:	$140 & 140
Alternative Rates:	$6.27/8.14/9.73/15.55

Current Open Access℠ Allowances: Examination up to $50, Single Vision up to $50, Lined Bifocal up to $75, Lined Trifocal up to $100, Lenticular up to $125, Frame up to $70, Elective Contact Lenses up to $105 & Necessary Contact Lenses $210.

Alternate Open Access℠ Allowances: Examination up to $45, Single Vision up to $30, Lined Bifocal up to $50, Lined Trifocal up to $65, Lenticular up to $100, Frame up to $70, Elective Contact Lenses up to $105 & Necessary Contact Lenses $210.

Renewal Options

___Option I	Renew with Current plan design
X Option II	Renew with Alternative Plan Design

Contract Period for all Options: July 1, 2015 through June 30, 2017

To renew your contract and maintain continuous service, please choose the option that best meets your needs, sign and return the Renewal Agreement by e-mail to jason.watkins@vsp.com, or fax to: 916-463-3926 by June 1, 2015. VSP will produce your renewal contract when we have received the Signed Renewal Agreement. Please review the new contract carefully, since some of the provisions may have changed from your prior contract. Additionally, please keep a copy of this Renewal Agreement and accompanying letter, given that they serve as your Notice of Renewal.

By: Melanie Bruketta

Title: HR Director

Date: 5.1.15

VSP Signature & Choice Plans

Below is a summary of benefits available with the VSP Signature and Choice Plans through VSP Preferred Providers. For a complete proposal or for a network access report, please contact your VSP Representative.

	VSP Signature Plan® *Premier Full-service Plan*	VSP Choice Plan® *Full-service Plan*
Provider Network	**VSP Network** 30,000 preferred providers 50,000 access points	**Choice Network** 30,000 preferred providers 50,000 access points
Network Disruption	0%	0%
Claim Disruption	0%	0%
WellVision Exam®	Thorough eye exam covered in full[1]	✓
Lenses	Glass or plastic, single vision, lined bifocal, lined trifocal, or lenticular prescription lenses are covered in full[1]	✓
Lens Options	All lens options are covered in full with a copay, saving our members an average of 35-40%	The most popular lens options are covered in full with a copay, saving our members an average of 20-25%[2]
	Patient cost[3]: Progressives: $50 Anti-reflective: $37 Photochromics: $62 Scratch resistant coating: $15 Polycarbonate: $23	Patient cost[3]: Progressives: $55 Anti-reflective: $41 Photochromics: $70 Scratch resistant coating: $17 Polycarbonate: $31
	Dependent children are eligible for covered in full polycarbonate prescription lenses	✓
Frame	Frames are covered in full[1] up to the retail allowance of $130 and/or $50 wholesale	✓
	20% off any amount above the allowance	✓
	Frame allowance backed by a wholesale guarantee, meaning VSP fully covers more frames compared to retail allowance plans	✓
Contact Lenses	15% off contact lens services, excluding materials	✓
	Instead of eyeglasses, elective contact lens services and materials are covered up to $130 toward any type of prescription contact lenses	✓
	Exclusive offers for VSP members include: Mail-in rebate savings[4] up to $60 on eligible Bausch & Lomb contacts and up to $125 on eligible ACUVUE Brand Contact Lenses	✓
	Necessary contact lenses are covered in full[1] for members who have specific conditions for which contact lenses provide better visual correction.	✓

	VSP Signature Plan® *Premier Full-service Plan*	VSP Choice Plan® *Full-service Plan*
Eye Health Management Program®	Includes member materials, care from VSP providers, and data that supports your wellness initiatives	✓
VSP GetFIT Program®	A free customizable wellness program for all your members and their dependents	✓
Laser VisionCare℠ Program	Discounts averaging 15-20% off or 5% off a promotional offer for laser surgery including PRK, LASIK, and Custom LASIK[5]	✓
Laser VisionCare℠ Program Value-added Benefits	Members who've had vision correction surgery can use their frame benefit for sunglasses, instead of a pair of prescription glasses	N/A
	30% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses[6]	20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses
Value-added Benefits	Guaranteed pricing that ensures members won't pay more than $39 for a routine retinal screening	✓
Sample Member Out-of-Pocket[7]	**Eye Exam: $10 copay**	**Eye Exam: $10 copay**
	Eyewear: $25 copay (Bifocal Lenses & Frame)	Eyewear: $25 copay (Bifocal Lenses & Frame)
Sample Member Out-of-Pocket[7] Plan Frequencies	Progressive Lenses: $50 **(Standard Add-On Option)**	Progressive Lenses: $55 **(Standard Add-On Option)**
	Total Member Out-of-Pocket: $85	Total Member Out-of-Pocket: $90
	Exam/Lenses/Frame 12/12/24	Exam/Lenses/Frame 12/12/24
Open Access Schedule	Eye Exam: $50 Single Vision: $50 Lined Bifocal: $75 Lined Trifocal: $100 Lenticular $125 Progressive: $75 Frame: $70 Elective Contact Lenses: $105 Medically Necessary Contact Lenses: $210	Eye Exam: $45 Single Vision: $30 Lined Bifocal: $50 Lined Trifocal: $65 Lenticular $100 Progressive: $50 Frame: $70 Elective Contact Lenses: $105 Medically Necessary Contact Lenses: $210

[1] Less any applicable copay.
[2] Most popular lens options include progressives, anti-reflective, photochromics, scratch resistant coating, polycarbonate, plastic dyes, and UV protection. All other lens options available at a 20% discount.
[3] Prices shown reflect the standard option price, prices on premium options may vary. Prices are valid only through VSP Preferred Providers and are subject to change without notice.
[4] Rebates subject to change.
[5] Using wavefront technology with the microkeratome surgical device only. Other LASIK procedures may be performed at an additional cost to the member. Laser VisionCare discounts are only available from VSP-contracted facilities.
[6] 30% discount applies to glasses purchased the same day as the member's eye exam from the same VSP Preferred Provider who provided the exam. Members will also receive 20% off unlimited additional pairs of glasses valid through any VSP Preferred Provider within 12 months of the last covered exam.
[7] The copy amounts are example amounts only and may be customized to meet specific needs.

May 6, 2015

Vision Care for Life

PAOLA LOUPE
CITY OF CARSON CITY
201 N CARSON ST STE 4
CARSON CITY, NV 89701-4289

RE: CITY OF CARSON CITY, GROUP #12072742
JULY 1, 2015 DOCUMENTS

Attention Paola Loupe:

Enclosed are your JULY 1, 2015 documents.

This new document supersedes any existing document you have with VSP. If you have any questions, or need additional information, please do not hesitate to contact us at 800-216-6248, and a VSP representative will assist you.

Enclosures

VISION SERVICE PLAN, INC.
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670

GROUP VISION CARE PLAN

Group Name	**CITY OF CARSON CITY**
Plan Number	**12072742**
State of Delivery	**NEVADA**
Effective Date	**JULY 1, 2015**
Plan Term	**TWENTY-FOUR (24) MONTHS**
Premium Due Date	**FIRST DAY OF MONTH**

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by the Group of the premiums as herein provided, VISION SERVICE PLAN, INC. ("VSP") agrees to insure certain individuals under this Group Vision Care Plan ("Plan") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Plan is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, which are a part of this Plan.

Robert L. Crowell, Mayor

James M. McGrann, Secretary

VISION SERVICE PLAN, INC.
GROUP VISION CARE PLAN
TABLE OF CONTENTS

VISION SERVICE PLAN, INC.
GROUP VISION CARE PLAN
SECTION I.
DEFINITIONS

Key terms used in this Plan are defined and shall have the meaning set forth as follows, unless the context of a term's usage clearly requires otherwise:

1.01. ADMINISTRATIVE SERVICES PROGRAM: A group vision care plan whereby Group pays VSP for the Plan Benefits in addition to a monthly administrative fee.

1.02. ANISOMETROPIA: A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

1.03. BENEFIT AUTHORIZATION: Authorization issued by VSP identifying the individual named as Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled.

1.04. CONFIDENTIAL MATTER: All confidential or personal information concerning the medical, personal, financial or business affairs of Covered Persons acquired in the course of providing Plan Benefits hereunder.

1.05. COPAYMENTS: Those amounts required to be paid by or on behalf of Covered Person for Plan Benefits which are not fully covered.

1.06. COVERED PERSON: An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and who is covered under this Plan.

1.07. ELIGIBLE DEPENDENT: Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP in Section VI. of this Plan under which such Enrollee is covered.

1.08. EMERGENCY CONDITION: A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.

1.09. ENROLLEE: An employee or member of Group who meets the criteria for eligibility specified under Section VI. Eligibility For Coverage.

1.10. EXPERIMENTAL NATURE: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.

1.11. GROUP: An employer or other entity which contracts with VSP for coverage under this Plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

1.12. GROUP APPLICATION: The form signed by an authorized representative of the Group to signify the Group's intention to have its Enrollees and their Eligible Dependents become Covered Persons of VSP.

1.13. GROUP VISION CARE PLAN (also, "The Plan"): The Plan issued by VSP in favor of a Group, under

which its Enrollees or members, and their Eligible Dependents are entitled to become Covered Persons of VSP and receive Plan Benefits in accordance with the terms of such Plan.

1.14. KERATOCONUS: A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

1.15. MEMBER DOCTOR: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

1.16. NON-MEMBER PROVIDER: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

1.17. PLAN ADMINISTRATOR: The person specifically so designated on the application, or if an administrator is not so designated, the Group. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Group.

1.18. PLAN BENEFITS: The vision care services and vision care materials that Covered Person is entitled to receive by virtue of coverage under this Plan, as defined in the Schedule of Benefits attached hereto as Exhibit A.

1.19. PREMIUMS: The payments made to VSP by Group on behalf of Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached hereto as Exhibit B.

1.20. RENEWAL DATE: The date on which the Plan shall renew, or expire if proper notice is given.

1.21. SCHEDULE OF BENEFITS: The document, attached hereto as Exhibit A, that lists the vision care services and vision care materials that Covered Person is entitled to receive by virtue of coverage under this Plan.

1.22. SCHEDULE OF PREMIUMS: The document, attached hereto as Exhibit B, which states the payments to be made to VSP by or on behalf of Covered Person to entitle him/her to Plan Benefits.

SECTION II.
TERM, TERMINATION, AND RENEWAL

2.01. **Plan Term**: This Plan shall become effective on the date first above stated, and shall remain in effect for the Plan Term. At the expiration of the Plan Term, the Plan shall renew on a month-to-month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Plan Term, that such party is unwilling to renew the Plan. If such notice is given, the Plan shall expire at 12:00 midnight on the last day of the Plan Term unless the parties reach mutual agreement on its renewal.

2.02. **Early Termination Provision**: The premium rate(s) payable by Group under this Agreement is based on an assumption that VSP will receive these amounts over the full Plan Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Plan Term. If this Agreement is terminated by Group before the end of the Plan Term or any subsequent renewal terms, for any reason other than material breach by VSP, Group will remain liable to VSP for the lesser amount of any deficit incurred by VSP or the payments which Group would have paid for the remaining term of this Plan, not to exceed one year. A deficit incurred by VSP will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by VSP from Group. Net premiums shall mean premiums paid by Group minus any applicable retention amounts and/or broker commissions. Group agrees to pay VSP within thirty-one (31) days of notification of the amount due.

SECTION III.
OBLIGATIONS OF VSP

3.01. **Coverage of Covered Persons**: VSP will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of whom shall be referred to upon enrollment as "Covered Persons." To institute coverage, Group may be required by VSP to complete and sign a Group Application and forward such application to VSP, along with information regarding Enrollees and Eligible Dependents, and all applicable Premiums. (Refer to Section VI. Eligibility For Coverage for further details.)

Following the enrollment of the Covered Person, VSP will make available to all Covered Persons a Member Benefit Summary. Such Member Benefit Summary will summarize the terms and conditions set forth in this Plan.

3.02. **Provision of Plan Benefits**: Through its Member Doctors (or through other licensed vision care providers where the Covered Person chooses to receive Plan Benefits from a Non-Member Provider), VSP shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits (Exhibit A hereto), subject to any limitations, exclusions, or Copayments therein stated. When the Covered Person desires to receive Plan Benefits from a Member Doctor, the Covered Person shall contact VSP or the Member Doctor. VSP shall provide Benefit Authorization to the Member Doctor or to the eligible Covered Person for use in receiving Plan Benefits from a Member Doctor. Benefit Authorization shall be issued by VSP in accordance with the latest eligibility information furnished by Group and past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the Member Doctor that payment will be made. VSP shall not be held liable to Group for any Benefit Authorizations so issued in error. Covered Persons are required to obtain the Benefit Authorization prior to obtaining Plan Benefits in cases where the Covered Person obtains Plan Benefits from a Member Doctor (see Section 5.03 for further details).

VSP shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after VSP has received a completed claim, unless special circumstances require additional time. In such cases, VSP may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.

3.03. **Provision of Information to Covered Persons**: VSP shall make available to the Covered Person necessary information describing Plan Benefits and the appropriate method for using them. A copy of this Plan shall be placed with Group and also will be made available at the offices of VSP for any Covered Persons who wish to inspect or copy it. VSP shall provide to Covered Persons an updated list of Member Doctors' names, addresses, and telephone numbers.

3.04. **Preservation of Confidentiality**: VSP shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, Member Doctors, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Plan, including but not limited to, sharing information with medical information bureaus, or as may otherwise be required by law.

3.05. **Emergency Vision Care**: When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a Member Doctor or Non-Member Provider. No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If Group has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Plan.

SECTION IV.
OBLIGATIONS OF THE GROUP

4.01. **Identification of Eligible Enrollees**: An Enrollee is eligible for coverage under this Plan if he/she satisfies the enrollment criteria specified in Paragraph 6.01(a) and/or as mutually agreed to by VSP and Group. By the effective date of this Plan, Group shall provide VSP with a listing, in a form approved by VSP, of all of its Enrollees who are eligible for coverage under this Plan as of that date and a designation of family status for each such Enrollee, if dependent coverage is provided. Thereafter, Group shall supply to VSP on or before the last day of each month, in a form approved by VSP, a listing of all Enrollees with a designation of family status who will be added to or deleted from VSP's coverage rosters for the succeeding month.

4.02. **Payment of Premiums**: On or before the first day of each month, Group shall remit to VSP the premiums payable for the succeeding month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Plan for such succeeding month. The amount of such Premiums for each Covered Person shall be as provided in the Schedule of Premiums incorporated in this Plan as Exhibit B. Only Covered Persons for whom Premiums are actually received by VSP shall be entitled to Plan Benefits hereunder and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Covered Person is not received by the time specified above, VSP reserves the right to terminate all rights of such Covered Person, and such rights may be reinstated only in accordance with the requirements of this Plan.

VSP may change the Premiums shown on the attached Schedule of Premiums, (Exhibit B) by giving Group at least sixty (60) days advance written notice. VSP may change the Premiums at any time the Schedule of Benefits or any other terms and conditions of this Plan are changed. No change will be made during the Plan Term unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Plan. No change will be made more often than once during any twelve (12) month period unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Plan.

Notwithstanding the above, VSP reserves the right to increase Premiums required hereunder by the amount of any tax or assessment not now in effect which is subsequently levied by any taxing authority, which is attributable to the Premiums VSP receives from Group.

4.03. **Grace Period**: Group shall be allowed a grace period of thirty-one (31) days following the due date for making any payment of Premiums due under this Plan. During said grace period, this Plan shall remain in full force and effect for all Covered Persons covered hereunder.

If Group fails to make any payment of Premiums due by the end of any grace period, VSP may notify Group that the payment of Premiums has not been made, that coverage is canceled and that the Group is responsible for payment of all Plan Benefits provided to Covered Persons after the last period for which Premiums were fully paid, including the grace period.

4.04. **Other Information to be Provided**: Group shall furnish to VSP monthly, during the effective period of this Plan, such information as may reasonably be required by VSP for the purposes of this Plan, including listings of new Enrollees, terminations of eligibility and changes in the family status of covered Enrollees. Such information shall be supplied in a form specified by VSP. In addition, Group shall, when requested, make available for inspection by VSP such records as may have bearing on the coverage of Covered Persons under this Plan.

4.05. **Distribution of Required Documents**: Group agrees to distribute to Enrollees any disclosure forms, plan summaries or other material that may be required to be given to plan subscribers by any regulatory authority. Such materials shall be distributed by Group to Enrollees no later than thirty (30) days after the receipt thereof.

4.06. **Risk-to-ASP Conversion Provision**: Converting to an Administrative Services Program: Due to the cyclical nature of vision care, in the event Group wishes to convert its method of funding from a risk program to an Administrative Services Program, an appropriate level of reserve will need to have been established.

Upon conversion to an Administrative Services Program, for vision care begun on and after the effective date of conversion, all claims will be paid through the Administrative Services Program.

SECTION V.
OBLIGATIONS OF COVERED PERSONS UNDER THE PLAN

5.01. **General**: By this Plan, Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. However, this Plan may be amended or terminated by agreement between VSP and Group without the consent or concurrence of the Covered Persons. This Plan, and all Exhibits, attachments and amendments attached hereto constitute VSP's sole and entire undertaking to Covered Persons under this Plan.

All Covered Persons under this Plan shall have the following obligations as a condition of their coverage.

5.02. **Copayments for Services Received**: Where, as indicated on the Schedule of Benefits, Exhibit A hereto, Copayments are required for certain Plan Benefits, these Copayments shall be the personal responsibility of the Covered Person receiving the care and must be paid to the Member Doctor on the date the services are rendered.

5.03. **Authorization of Services**: The Covered Person must receive Benefit Authorization before receiving Plan Benefits from a Member Doctor. Such Benefit Authorization is received by contacting a Member Doctor or VSP. Should the Covered Person receive Plan Benefits from a Member Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the provider will be considered a Non-Member Provider, and the benefits available will be limited to those for a Non-Member Provider, if any.

5.04. **Complaints and Grievances: Time of Action**: Covered Persons shall report any complaints and/or grievances to VSP at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to VSP verbally or in writing. Covered Person may submit written comments or supporting documentation concerning his/her complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution, VSP will notify the Covered Person of the outcome in writing.

5.05. **Insurance Fraud**: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SECTION VI.
ELIGIBILITY FOR COVERAGE

6.01. **Eligibility Criteria**: Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.

(a) **Enrollees**: To be eligible for coverage, a person must:

(1) currently be an employee or member of Group; and

(2) meet the coverage criteria mutually agreed upon by Group and VSP.

(b) **Eligible Dependents**: If dependent coverage is provided, the persons eligible for dependent coverage as dependents shall include:

(1) the legal spouse of any Enrollee; and

(2) any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement in the residence of the Enrollee, or other child for whom a court holds the Enrollee responsible; and who has not yet attained the age of 26 years, or

(3) as further defined by Group.

If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he/she remains a dependent and the Enrollee's coverage remains in force; provided however, that satisfactory proof of the dependent's incapacity can be furnished to VSP within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated or at such other times as VSP may request proof, but not more frequently than annually.

6.02. **Documentation of Eligibility**: Persons satisfying the coverage requirements under either of the above criteria shall be eligible if:

(a) for an Enrollee, the individual's name and Social Security Number have been reported by Group to VSP in the manner provided hereunder; and

(b) in the case of changes to a Dependent's status, the change has been reported by the Group to VSP in the manner provided herein.

As stated in Section 4.04. herein, VSP may elect to inspect the Group's records in order to verify eligibility of Enrollees and Dependents. Plan Benefits will be available only to persons on whose behalf Premiums have been paid for the current period, or grace periods outlined herein in Section 4.03. If a clerical error is made, it will not affect the coverage to which the Covered Person is entitled under the Plan.

6.03. **Change of Participation Requirements, Contribution of Fees, and Eligibility Rules**: Composition of the Group, percentage of Enrollees covered under the Plan, and eligibility requirements are material to VSP's obligations under this Plan. During the term of this Plan, Group may not change its composition, percentage of Enrollees covered, or eligibility requirements in any way that affects VSP's obligations hereunder unless VSP consents to such change in writing. VSP may require the Group to make written request for any such change at least sixty (60) days prior to the proposed effective date of the change. Nothing herein shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Plan.

6.04. **Change in Family Status**: In the event of any change in the Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of dependent children, etc.], written notice in a form acceptable to VSP is to be given to VSP by the Covered Person, or by someone else acting on the Covered Person's behalf, within thirty-one (31) days of such change. If such notice is given, the change in the Covered Person's status will become effective on the first day of the month following the request for change, or at such later date as may be requested by or on behalf of the Covered Person. A natural or adopted newborn will be covered from the moment of birth when timely notice of the addition is given.

SECTION VII.
CONTINUATION OF COVERAGE

7.01. **COBRA**: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent that COBRA applies, VSP shall make the statutorily-required COBRA continuation coverage available for purchase in accordance with COBRA.

SECTION VIII.
CLAIMS DENIAL APPEALS AND ARBITRATION OF DISPUTES

8.01. **Claims Denial Appeals**: If, under the terms of this Plan, a claim is denied in whole or in part, a request may be submitted to VSP by Covered Person or Covered Person's authorized representative for a full review of the denial. Covered Person may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

a) **Initial Appeal**: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the Enrollee's name, the Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

Denied Claims for Services Rendered: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

b) **Second Level Appeal**: If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) **Other Remedies**: When Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Group should advise Covered Person to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

8.02. **Disputes**: Any dispute or question arising between VSP and Group or any Covered Person involving the application, interpretation, or performance under this Plan shall be settled, if possible by amicable and informal negotiations allowing such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration.

8.03. **Procedure for Arbitration**: The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

SECTION IX.
NOTICES

9.01. **Notices**: Any notices required under this Plan to either Group or VSP shall be in written format. Notices sent to the Group will be sent to the address or email address shown on the Group's Application unless otherwise directed by Group. Notices to VSP shall be sent to the address shown on the front page of this Plan. Notwithstanding the above, any notices may be hand-delivered by either party to an appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

SECTION X.
MISCELLANEOUS

10.01. **Entire Plan**: This Plan, the Group Application, the Evidence of Coverage, and all Exhibits, addenda and attachments, and any amendments hereto, constitute the entire understanding between the parties and supersede any prior understandings and agreements between them, either written or oral. Any change or amendment to the Plan must be approved by an officer of VSP and attached hereto to be valid. No agent has the authority to change this Plan or waive any of its provisions.

10.02. **Indemnity**: VSP agrees to indemnify, defend and hold harmless Group, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of VSP, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Group agrees to indemnify, defend and hold harmless VSP, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Group, its officers, agents or employees to perform any of the duties or responsibilities specified herein.

10.03. **Liability**: Under no circumstances shall VSP or Group be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with this Plan.

10.04. **Right to Reject Claims**: VSP reserves the right to reject any and all claims for services or benefits that are filed with it more than three hundred sixty-five (365) days after completion of services.

10.05. **Assignment**: Neither this Plan nor any of the rights or obligations of either of the parties hereto may be assigned or transferred, except as may be expressly authorized and provided herein, without the prior written consent of both parties hereto.

10.06. **Severability**: Should any provision of this Plan be declared invalid, the remaining provisions shall remain in full force and effect.

10.07. **Choice of Law**: If there are any matters arising in connection with this Plan that become the subject of legal process, the applicable law shall be that of the state of delivery of this Plan.

10.08. **Gender**: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

10.09. **Equal Opportunity Employer**: All communication materials created by Group that relate to this vision care Plan must be approved by VSP in advance of mailing to Enrollees.

10.10. **Communication Materials**: All communication materials created by Group that relate to this vision care Plan must be approved by VSP in advance of mailing to Enrollees.

10.11. **Replacement of Coverage**: Replacement coverage of vision benefits provided within a period of sixty (60) days from the date of discontinuance of a prior policy providing vision benefits shall immediately cover all Enrollees and Eligible Dependents validly covered under the previous plan at the date of discontinuance who are within the definitions of eligibility and who would otherwise be eligible for coverage under the succeeding carrier's plan, regardless of any limitations or exclusions relating to active employment or non-confinement.

EXHIBIT A

VISION SERVICE PLAN, INC.
SCHEDULE OF BENEFITS
VSP Choice Plan

GENERAL

This Schedule lists the vision care benefits to which Covered Persons of VISION SERVICE PLAN, INC. ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Plan or Evidence of Coverage to which it is attached.

Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

PLAN BENEFITS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
VISION CARE SERVICES		
Eye Examination	Covered in Full*	Up to $ 45.00*

Complete initial vision analysis that includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

*Less any applicable Copayment.
Subsequent regular eye examinations **every 12 months**.

VISION CARE MATERIALS

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Lenses		
Single Vision	Covered in Full*	Up to $ 30.00*
Bifocal	Covered in Full*	Up to $ 50.00*
Trifocal	Covered in Full*	Up to $ 65.00*
Lenticular	Covered in Full*	Up to $ 100.00*

*Less any applicable Copayment

Available once every 12 months.

Frames	Covered up to Plan Allowance*	Up to $ 70.00*

*Less any applicable Copayment.

Available once every 24 months.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available **once every 12 months** in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

NECESSARY

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Professional Fees and Materials - Covered in Full*	Professional Fees and Materials - Up to $ 210.00*

ELECTIVE

MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Materials - Up to $ 140.00 Elective Contact Lens fitting and evaluation** services are covered in full once every 12 months, after a maximum $60.00 Copayment.	Professional Fees and Materials - Up to $ 105.00

*Less any applicable Copayment
**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

COPAYMENT

The benefits described above are available to each Covered Person from any participating Member Doctor at no cost to the Covered Person, with the exception of any applicable Copayment as described below.

There shall be a Copayment of $25.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

LOW VISION BENEFIT

The Low Vision benefit is available to Covered Persons who have severe visual problems that are not correctable with regular lenses.

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
Supplementary Testing	Covered in Full	Up to $125.00*
Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.		
Supplementary Care	75% of Cost	75% of Cost*
Subsequent low vision therapy.		

Copayment

75% of the benefits payable by the Company and 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is $1,000.00 (excluding Copayment) every two years.

***NON-MEMBER BENEFIT**

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Covered Person should pay the Non-Member Provider his/her full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Doctor in similar circumstances.

NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;

- Replacement of lenses and frames furnished under this Plan that are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Any eye examination or any corrective eyewear required by an employer as a condition of employment;

- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

VSP MAY, AT ITS DISCRETION, WAIVE ANY OF THE PLAN LIMITATIONS IF, IN THE OPINION OF VSP'S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE COVERED PERSON.

Exhibit B

VISION SERVICE PLAN, INC.
SCHEDULE OF PREMIUMS
VSP Choice Plan

VSP shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$	6.27	per month for each eligible Enrollee without dependents.
$	8.14	per month for each eligible Enrollee with an eligible spouse.
$	9.73	per month for each eligible Enrollee with eligible child(ren).
$	15.55	per month for each eligible Enrollee with eligible spouse and child(ren).

NOTICE: The premium under this Plan is subject to change upon renewal (after the end of the initial Plan Term or any subsequent Plan Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Plan.

ADDENDUM

VISION SERVICE PLAN, INC.
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN, INC. are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the PLAN or Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this PLAN, pursuant to eligibility criteria established by Client:

- Enrollee.
- The legal spouse of Enrollee.
- The domestic partner of the same or opposite gender as Enrollee, pursuant to Group's eligibility.
- A dependent parent of Enrollee if such dependent parent is recognized as an eligible dependent under Group's requirements.
- Any child of an Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible.

Dependent children are covered up to age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Covered Persons group medical plan. Providers will first submit a claim to Covered Persons group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- "floating" spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

If Covered Person Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Person receive the appropriate level of care for their presenting condition. Covered Person do not require a referral from a Member Doctor in order to obtain Plan Benefits.

PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Person upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.

PLAN BENEFITS
NON-MEMBER PROVIDERS

A Non-Member Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examination: Covered up to $ 100.00 after a $20.00 Copayment.

Special Ophthalmological Services: Covered up to $120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Non-Member Providers.
2. Services from a Non-Member Provider are in lieu of services from a Member Doctor.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Non-Member Providers to adhere to VSPs quality standards.

Group Vision Care Plan

Vision Care for Life

Group Name: CITY OF CARSON CITY
Group Number: 12072742
Effective Date: JULY 1, 2015

Evidence of Coverage

Provided by:

VISION SERVICE PLAN, INC.
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

To be filled in by employer in the event this document is used to develop a Summary Plan Description:

NAME OF EMPLOYER:
NAME OF PLAN:
PRINCIPAL ADDRESS:

EMPLOYER I.D.#:

PLAN #:

PLAN ADMINISTRATOR:
ADDRESS:

PHONE NUMBER:

REGISTERED AGENT FOR SERVICE OF LEGAL PROCESS, IF DIFFERENT FROM PLAN ADMINISTRATOR:

ADDRESS:

This form is a summary of the Plan provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Plan itself. A copy of the Plan will be furnished on request.

DEFINITIONS:

ADDITONAL BENEFIT RIDER	The document attached to this Evidence of Coverage,when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.
ANISOMETROPIA	A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.
BENEFIT AUTHORIZATION	Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.
COPAYMENTS	Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits that are not fully covered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.
ELIGIBLE DEPENDENT	Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP under the provisions of the Plan under which such Enrollee is covered.
EMERGENCY CONDITION	A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.
ENROLLEE	An employee or member of Group who meets the criteria for eligibility specified under the provisions of the Plan.
EXPERIMENTAL NATURE	Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
GROUP	An employer or other entity which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
KERATOCONUS	A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

MEMBER DOCTOR An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP.

NON-MEMBER PROVIDER Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

PLAN BENEFITS The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Plan, as defined on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.

PREMIUMS The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group Administrator.

RENEWAL DATE The date on which the Plan shall renew or terminate if proper notice is given.

SCHEDULE OF BENEFITS The document, attached as Exhibit A to the Group Plan document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this plan.

SCHEDULE OF PREMIUMS The document, attached as Exhibit B to the Group Plan document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

BENEFITS AND COVERAGES

IMPORTANT: The benefits described below are typical services and materials available under most VSP plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.

3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.

4. Contact lenses: Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses..

   Elective or Necessary contact lenses are available in lieu of spectacle lenses and frames for the current eligibility as indicated on the enclosed insert.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the additional cost for the options, unless the extra is defined in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

Although a low vision benefit is available to Insureds diagnosed as having severe visual problems (i.e., partial sight), it is subject to limitations. Consult your Member Doctor or Benefits Representative for details. **There is no benefit for professional services or materials connected with:**

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.

2. Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available.

3. Medical or surgical treatment of the eyes.

4. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.

5. Corrective vision treatment of an experimental nature such as, but not limited to, RK and PRK Surgery.

ELIGIBILITY FOR COVERAGE

Enrollees: To be eligible for coverage, a person must currently be an employee or member of the Group, and meet the criteria established in the coverage criteria mutually agreed upon by Group and VSP.

Eligible Dependents: If dependent coverage is provided, the persons eligible for coverage as dependents shall include the legal spouse of any Enrollee, and any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement in the residence of the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible from the moment of birth who has not obtained the limiting age as shown on the enclosed insert page.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon the enrollee for support and maintenance.

PREMIUMS

The Group is responsible for payments to VSP of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group. The entire cost of the program is paid to VSP by the Group.

COPAYMENT

The benefits described herein are available to you from any participating Member Doctor, provided you follow the proper procedures by obtaining Benefit Authorization. THERE MAY BE A COPAYMENT AMOUNT PAYABLE BY YOU TO THE MEMBER DOCTOR AT THE TIME OF THE EXAMINATION. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

CHOICE OF PROVIDERS

Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. If you elect to receive vision care services from one of the Member Doctors, covered services are provided at no out-of-pocket cost (unless the plan contains a Copayment).

When vision care services are received from a Non-Member Provider, you will be reimbursed for such benefits according to the schedule shown on the enclosed insert, less any applicable Copayment.

BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Insured by Group under this Plan. When Covered Person requests services under this Plan, Covered Person prior utilization of Plan Benefits will be reviewed by VSP to determine if Insured is eligible for new services based upon Covered Person's Plan level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

PROCEDURE FOR USING THE PLAN

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or the Member Doctor. If you are eligible, VSP will provide Benefit Authorization to you or the Member Doctor.

2. When such authorization is received and services are performed prior to the expiration date of the authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

3. A list of Member Doctors in your geographic location can be obtained from your Group or Plan Administrator. This list contains the names, addresses, and telephone numbers of the Member Doctors. If this list does not cover the geographic area in which you desire to seek services, you may call or write VSP office nearest you to obtain one that does.

4. You pay only the Copayment (if any) to the doctor for the services covered by the Plan. VSP will pay the Member Doctor directly according to its agreement with the doctor.

5. In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider - if the attached Schedule of Benefits indicates that Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance. Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

LIABILITY IN EVENT OF NON-PAYMENT

IN THE EVENT COMPANY FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE LIABLE TO THE PROVIDER FOR ANY SUMS OWED BY THE VISION PLAN OTHER THAN THOSE NOT COVERED BY THE PLAN.

INDIVIDUAL CONTINUATION OF BENEFITS

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

TERMINATION OF BENEFITS

Terms and cancellation conditions of your vision care plan are shown on the enclosed insert. If service is being rendered to you as of the termination date of the Plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Plan.

COMPLAINTS AND GRIEVANCES

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of Covered Person, the Covered Person may communicate a complaint or grievance to VSP, orally or in writing, by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Insured to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

A. **Initial Determination**: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. **Request for Appeals**: If the Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the Enrollee, Member Identification Number of the Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Insured believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination.VSP shall resolve any second level appeal within thirty (30) calendar days.

When Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

OTHER FACTS YOU SHOULD KNOW ABOUT THE PLAN

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents such as detailed annual reports and Plan descriptions, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor or the Internal Revenue Service.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and your claim reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent to you because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent COBRA applies, VSP shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

The Plan Administrator and the employer are subject to numerous obligations in connection with continuation coverage, including an obligation to notify eligible participants and their dependents of the existence of said continuation coverage. In this regard, the U.S. Department of Labor has issued ERISA Technical Release No. 86-2 dated June 26, 1986, setting forth a Model Statement of the required notice. Providing said notice by first class mail to each covered employee and his or her spouse, if any, at their last known address will constitute a good faith effort at compliance of the notice requirement in the absence of promulgated COBRA regulations.

VISION SERVICE PLAN, INC.
3333 Quality Drive
Rancho Cordova, CA 95670

Group Name: CITY OF CARSON CITY

Plan Number: 12072742

Effective Date: JULY 1, 2015

Plan Term: TWENTY-FOUR (24) MONTHS

VISION CARE PLAN
DISCLOSURE FORM AND EVIDENCE OF COVERAGE

PLAN ADMINISTRATOR:

Paola Loupe
(Name)
201 N Carson St Ste 4
(Address)
Carson City, NV 89701-4289
(City, State, Zip)

MONTHLY PREMIUM:

YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.

ELIGIBILITY:

ENROLLEES & ELIGIBLE DEPENDENTS: DEPENDENT CHILDREN ARE COVERED TO AGE 26. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.

PLAN AND SCHEDULE:

VSP CHOICE PLAN

EXAMINATION:	*ONCE EVERY 12 MONTHS.*
LENSES:	*ONCE EVERY 12 MONTHS.*
FRAMES:	*ONCE EVERY 24 MONTHS.*

TERM, TERMINATION AND RENEWAL:

AFTER THE PLAN TERM, THIS PLAN WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.

TYPE OF ADMINISTRATION:

BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.

VSP'S ADDRESS IS:

VISION SERVICE PLAN
3333 QUALITY DRIVE
RANCHO CORDOVA, CA 95670

SCHEDULE OF BENEFITS

GENERAL

This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.

Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.

PLAN BENEFITS	***MEMBER DOCTOR BENEFIT***	***NON-MEMBER PROVIDER BENEFIT***
VISION CARE SERVICES		
Vision Examination	*Covered in Full**	*Up to $ 45.00**
VISION CARE MATERIALS		
Lenses		
Single Vision	*Covered in Full**	*Up to $ 30.00**
Bifocal	*Covered in Full**	*Up to $ 50.00**
Trifocal	*Covered in Full**	*Up to $ 65.00**
Lenticular	*Covered in Full**	*Up to $ 100.00**
Frames	*Covered up to Plan Allowance**	*Up to $ 70.00**
CONTACT LENSES		
Necessary		
Professional Fees and Materials	*Covered in Full**	*Up to $ 210.00**
Elective	*Materials*	*Professional Fees and Materials*
	Up to $ 140.00	*Up to $ 105.00*
	*Elective Contact Lens fitting and evaluation** services are covered in full once every 12 months, after a maximum $60.00 Copayment.*	

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Member Doctor or Non-Member Provider. Prior review and approval by VSP are not required for Covered Person to be eligible for Necessary Contact Lenses.

When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months.

***Subject to Copayment, if any.**

****15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.***

COPAYMENT

There shall be a Copayment of $25.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to Elective Contact Lenses.

LOW VISION

Professional services for severe visual problems not corrected with regular lenses, including:

Supplemental Testing	*Covered in Full*	*Up to $125.00*
(includes evaluation, diagnosis and prescription of vision aids where indicated)		
Supplemental Aids	*75% of cost*	*75% of cost*

Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.

THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.

ADDENDUM

VISION SERVICE PLAN, INC.
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN, INC. are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Program are available to Covered Persons who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the plan or Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this plan, pursuant to eligibility criteria established by Client:

- Enrollee.
- The legal spouse of Enrollee.
- The domestic partner of the same or opposite gender as Enrollee, pursuant to Group's eligibility.
- A dependent parent of Enrollee if such dependent parent is recognized as an eligible dependent under Group's requirements.
- Any child of an Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible.

Dependent children are covered up to age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Covered Persons group medical plan. Providers will first submit a claim to Covered Persons group medical insurance plan, and then to VSP. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Covered Person does not have a group medical plan, providers will submit claims directly to VSP.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- "floating" spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

If Covered Persons Member Doctor cannot provide Covered Services, the doctor will refer the Covered Person to another Member Doctor or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of DEP Plus, the Member Doctor will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Person receive the appropriate level of care for their presenting condition. Covered Persons do not require a referral from a Member Doctor in order to obtain Plan Benefits.

PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Covered Person upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes	A disease where the pancreas has a problem either making, or making and using, insulin.
Type 1 Diabetes	A disease in which the pancreas stops making insulin.
Type 2 Diabetes	A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.
Diabetic Retinopathy	A weakening in the small blood vessels at the back of the eye.
Rubeosis	Abnormal blood vessel growth on the iris and the structures in the front of the eye.
Diabetic Macular Edema	Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.

PLAN BENEFITS
NON-MEMBER PROVIDERS

A Non-Member Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examination: Covered up to $ 100.00 after a $20.00 Copayment.

Special Ophthalmological Services: Covered up to $120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for Member Doctors shall also apply to services rendered by Non-Member Providers.
2. Services from a Non-Member Provider are in lieu of services from a Member Doctor.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Non-Member Providers to adhere to VSPs quality standards.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: CITY OF CARSON CITY
Group ID: 12072742
Effective Date: JULY 1, 2015

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$25.00 Copay	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $25.00 Copay (lenses and/or frames only); Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 50.00 Tri-Focal Lenses reimbursed up to $ 65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first date of service.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Summary of Benefits and Coverage
SIGNATURE PLAN

Prepared for: CITY OF CARSON CITY
Group ID: 12072742
Effective Date: JULY 1, 2015

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$25.00 Copay	Reimbursed up to $50.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $25.00 Copay (lenses and/or frames only); Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 50.00 Bi-Focal Lenses reimbursed up to $ 75.00 Tri-Focal Lenses reimbursed up to $100.00 Lenticular Lenses reimbursed up to $125.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first date of service.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.