AMENDMENT #1 TO AGREEMENT NO. A-14566 BY AND BETWEEN COUNTY OF MONTEREY AND VISION SERVICES PLAN (VSP)

THIS AMENDMENT is made to the AGREEMENT for the provision of Vision Plan benefits and third-party administration of the County's Self-Insured Vision Plan by and between **VISION SERVICES PLAN (VSP),** hereinafter "CONTRACTOR", and the County of Monterey, a political subdivision of the State of California, hereinafter referred to as "County".

WHEREAS, the County and CONTRACTOR wish to amend the AGREEMENT to extend the term, increase the administrative fee, and update the Schedule of Benefits (Exhibit A).

NOW THEREFORE, the County and CONTRACTOR hereby agree to amend the AGREEMENT in the following manner:

1. **Section 3.0 TERM OF AGREEMENT, paragraph 3.1 shall be amended by removing,** "The term of this AGREEMENT is from January 1, 2020 through and including December 31, 2024, with the option to extend this AGREEMENT for three (3) additional one (1)-year periods." **and replacing it with,** "The term of this AGREEMENT is from January 1, 2020 through and including December 31, 2027, with the option to extend this AGREEMENT for two (2) additional mutually agreed periods."

2. **Section 4.0 COMPENSATION AND PAYMENTS, paragraph 4.1 shall be amended by removing,** "CONTRACTOR shall be entitled to receive an Administration Fee of $1.44 per enrollee (includes coverage for eligible dependents) per month." **and replacing it with,** "CONTRACTOR shall be entitled to receive an Administrative Fee of $1.58 per enrollee (includes coverage for eligible dependents) per month effective January 1, 2025 through December 31, 2027."

3. **EXHIBIT A – SCHEDULE OF BENEFITS** to the Agreement is hereby deleted and replaced in its entirety by **EXHIBIT A1 – SCHEDULE OF BENEFITS**, attached hereto, effective January 1, 2025.

4. Except as provided herein, all remaining terms, conditions and provisions of the AGREEMENT are unchanged and unaffected by this AMENDMENT and shall continue in full force and effect as set forth in the AGREEMENT.

5. A copy of this AMENDMENT shall be attached to the original AGREEMENT executed by the County on November 28, 2019.

IN WITNESS WHEREOF, the parties have executed this AMENDMENT on the day and year written below.

MONTEREY COUNTY	CONTRACTOR
	By:
Contracts/Purchasing Officer	Signature of Chair, President, or Vice-President
Dated:	
	Printed Name and Title
Approved as to Fiscal Provisions:	Dated:
Deputy Auditor/Controller	
Dated:	By:
	(Signature of Secretary, Asst. Secretary, CFO, Treasurer or Asst. Treasurer)*
Approved as to Liability Provisions:	
	Printed Name and Title
Risk Management	Dated:
Dated:	
Approved as to Form:	
Deputy County Counsel	
Dated:	

*INSTRUCTIONS: If CONTRACTOR is a corporation, including limited liability and non-profit corporations, the full legal name of the corporation shall be set forth above together with the signatures of two specified officers. If CONTRACTOR is a partnership, the name of the partnership shall be set forth above together with the signature of a partner who has authority to execute this Agreement on behalf of the partnership. If CONTRACTOR is contracting in an individual capacity, the individual shall set forth the name of the business, if any, and shall personally sign the Agreement.

EXHIBIT A1 – SCHEDULE OF BENEFITS

This Schedule of Benefits is effective January 1, 2025

GENERAL

This schedule lists the vision care services and vision care materials to which Covered Persons of VISION SERVICE PLAN (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, vison 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 Certificate to which it is attached.

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 available and 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.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for the Plan Benefits received from Member Doctors and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

There shall be a copayment of **$10.00** for the WellVision Exam 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. There shall be a **$30.00** copayment for progressive lens coverage. However, the copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

Vision Care Services

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
WELLVISION EXAM	Covered in Full*	Up to $40.00*

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

Subsequent regular eye examinations every 12 months.

*Note: Less any applicable copayment.

Vision Care Materials

	MEMBER DOCTOR BENEFIT	NON-MEMBER PROVIDER BENEFIT
FRAMES		
	• $160 allowance for a wide selection of frames • $180 allowance for featured frames (see vsp.com for more details) • 20% off amount over allowance • $90 Costco/Walmart/Sam's Club frame allowance	Up to $45.00
LENSES		
Single Vision	Covered in full*	Up to $40.00
Lined Bifocal	Covered in full*	Up to $60.00
Lined Trifocal	Covered in full*	Up to $80.00
Lenticular	Covered in full*	Up to $125.00
Polycarbonate (dependent children)	Covered in full*	N/A
LENS ENHANCEMENTS		
Standard progressive	Covered in full*	Up to $80.00
Premium progressive	Covered in full*	Up to $80.00
Custom progressive	Covered in full*	Up to $80.00
Other enhancements	Average 35-40% off	N/A

*Note: Less any applicable copayment.

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

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

CONTACTS (instead of glasses)
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 again for 12 months and frames for 12 months.

Visually Necessary – When Visually Necessary contact lenses are obtained from a Member Doctor, they will be covered in full with prior authorization from CONTRACTOR. When Visually Necessary contact

lenses are obtained from a Non-Member Provider, CONTRACTOR will provide an allowance up towards the cost as outlined below. Coverage for Visually Necessary contact lenses regardless of whether they are obtained from a Member Doctor or Non-Member Provider are subject to review and authorization from CONTRACTOR's Optometric Consultants.

	MEMBER DOCTOR BENEFIT	**NON-MEMBER PROVIDER BENEFIT**
Visually Necessary Contact Lenses Professional Fees and Materials	Covered in Full*	Up to $210.00*
Elective Contact Lenses (Contact Lenses for other than Visually Necessary circumstances) Professional Fees and Materials	Up to $160.00	Up to $105.00

Contact lens evaluation and fitting shall be covered-in-full after a copay, which will not exceed $60.

*Note: Less any applicable copayment.

EXTRA SAVINGS & DISCOUNTS
Each Covered Person shall be entitled to receive the following savings and discounts:

Glasses and Sunglasses
- Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as the WellVision Exam, or get 20% from any VSP provider within 12 months of the last WellVision Exam.

Retinal Screening
- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

Laser Vision Correction
- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.
- After surgery, frame allowance may be used for non-prescription sunglasses from any VSP doctor.

Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

LIMITATIONS:
- Discounts do not apply to vision care benefits obtained from Non-Member Providers.
- 30% or 20% discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.

- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

**Note: Professional judgement will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.

Low Vision Benefit
The Low Vision Benefit is available to Covered Persons who have severe visual problems not correctable with regular lenses and is subject to prior approval by CONTRACTOR Consultants.

	MEMBER DOCTOR BENEFIT	**NON-MEMBER PROVIDER BENEFIT**
Supplementary Testing	Covered in Full	Up to $125.00

Complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vison aids as Visually Necessary or Appropriate.
Copayment for Supplemental Aids: 25% payable by Covered Person.

BENEFIT MAXIMUM
The maximum Low Vision Benefit available is $1,000.00 (excluding copayment) every two years.

NON-MEMBER PROVIDER BENEFIT
Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and copayment arrangements as described for Member Doctor. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what CONTRACTOR would pay a Member Doctor in similar circumstances. Note: There is no assurance that this amount will be within 25% copayment feature.

Exclusion and Limitation of Benefits

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, and the Covered Person will pay the additional cost 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;
- Progressive multifocal lenses;
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2;
- UV (ultraviolet) protected lenses;
- Certain limitation on low vision care;
- A frame that cost more than the Plan allowance;
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

There is no benefit 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 which are lost of broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an Experimental Nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

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

ADDITIONAL BENEFIT – COMPUTER VISIONCARE (CVC) PLAN

This Schedule lists the vision care services and vision care materials to which Covered Persons of CONTRACTOR are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. This Schedule forms a part of the Plan or Certificate to which it is attached.

THIS IS AN EMPLOYEE-ONLY IN-NETWORK BENEFIT.

EYE EXAMINATION

A complete initial analysis which includes an appropriate examination of visual functions to determine the presence of vision problems or other abnormalities is covered through the base plan's exam benefit.

A supplemental vision analysis of the eyes and related structures will be provided to determine visual needs specific to CVC eyecare requirements.

Each eligible Covered Person shall be entitled to a supplemental eye examination based on the frequency as indicated on the attached CVC Schedule of Benefits.

MATERIALS

A. LENSES - The CONTRACTOR's Doctor will order proper lenses necessary for the CVC operator's visual welfare.

Each Covered Person is entitled to new lenses based on the frequency as indicated on the attached CVC Schedule of Benefits.

B. FRAMES - New frames will be provided based on the frequency as indicated on the attached CVC Schedule of Benefits.

CONTRACTOR reserves the right to limit the cost of the frames provided by CONTRACTOR's Doctor under the Plan. The current allowance shall be published periodically by CONTRACTOR to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.

ASSOCIATED VISION THERAPY

This benefit is limited to Covered Persons who are eligible for CVC coverage who have one of the following diagnoses:

- Accommodative Infacility – The inability (or inefficiency) to change focus quickly when looking form one distance to another or the inability to maintain focus at one distance for a prolonged period of time (Primarily when looking at things up close).
- Convergence Insufficiency – The occasional problem with the eye muscle's ability to point the eyes straight when working up close.

The maximum annual benefit is $200.00. A copayment is not required from the Covered Person.

COPAYMENT

The benefits described herein are available to each eligible Covered Person from any participating Member Doctor at no cost to the Covered Person, provided Covered Person follows the proper procedures by obtaining Benefit Authorization.

A COPAYMENT AMOUNT AS INDICATED ON THE ATTACHED CVC SCHEDULE OF BENEFITS SHALL BE PAYABLE BY THE COVERED PERSON TO THE MEMBER DOCTOR AT THE TIME OF SERVICE.

Exclusion and Limitation of Benefits

PATIENT OPTIONS

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

- Blended lenses;
- Oversize lenses;
- Cosmetic lenses;
- Optional cosmetic processes;
- Solid and gradient plastic dyes, non-pink or non-rose tints, 20% tint or less;
- Progressive multifocal lenses;
- Edge, color and anti-reflective coatings;
- UV (ultraviolet) protected lenses;
- A frame that costs more than the plan allowance.

NOT COVERED
There is no benefit for professional services or materials connected with:

- Subnormal vision aids;
- Orthoptics or vision training and any associated supplementary testing not specifically related to working with a CVC; plano lenses; or two pair of glasses in lieu of bifocals;
- Contact lenses;
- Photochromic or tints greater than 20%;
- Laminated lenses;
- Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes.

CONTRACTOR may, at its discretion, waive any of the plan limitations if, in the opinion of our optometric consultants, this is necessary for the visual welfare of the Covered Person.

CVC Schedule of Benefits

SERVICES FROM MEMBER DOCTORS

Frames

- $95 allowance for a wide selection of frames
- $115 allowance for featured frames (see vsp.com for more details)
- 20% off the amount over allowance

Lenses

Single vision, lined bifocal, lined trifocal, and occupational lenses are covered in full, less applicable copayment stated below.

Frequency
Frames and lenses are covered every 12 months. The exam is included with the WellVision Exam.

Copayment
The copayment for frame and lenses combined is $20.00.

SERVICES FROM NON-MEMBER PROVIDERS

Liability of Covered Persons Payment Reimbursement Provisions
When a Covered Person chooses to go to a Non-Member provider, services may be secured from any optometrist, ophthalmologist and/or dispensing optician. This plan then becomes an indemnity plan reimbursing according to a schedule of allowances. The Covered Person should pay the doctor his full fee. CONTRACTOR will reimburse in accordance with the following schedule. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS.

AVAILABILITY OF SERVICES UNDER THIS REIMBURSEMENT SCHEDULE IS SUBJECT TO THE SAME TIME LIMITS AND COPAYMENT AS THOSE DESCRIBED FOR MEMBER

SERVICES. SERVICES OBTAINED FROM A NON-MEMBER PROVIDER ARE IN LIEU OF OBTAINING SERVICES FROM A PANEL MEMBER OF CONTRACTOR.

CONTRACTOR IS UNABLE TO REQUIRE NON-MEMBER PROVIDERS TO UPHOLD CONTRACTOR'S QUALITY STANDARDS.

MAXIMUM REIMBURSEMENT FOR SERVICES FROM NON-MEMBER PROVIDERS

Materials	Allowance
Eye Examination, up to	$0.00*
Single Vision Lenses, up to	$18.00*
Bifocal Lenses, up to	$50.00*
Trifocal Lenses, up to	$100.00*
Lenticular Lenses, up to	$125.00*
Frame, up to	$45.00*

*Note: Less any applicable Copayment.