

**CITY CLERK
ORIGINAL**



**C-8733
07/01/2011**

LUPE SIERRA
GLENDALE, CITY OF
5850 W GLENDALE AVE STE B56
GLENDALE, AZ 85301-2563

**RE: CITY OF GLENDALE, GROUP #12132192
JULY 1, 2011 DOCUMENTS**

Attention Lupe Sierra:

Enclosed are your JULY 1, 2011 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 me at 916-858-5744.

Matthew Alvarez
Vision Service Plan

Enclosures



VISION SERVICE PLAN INSURANCE COMPANY
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670

GROUP VISION CARE POLICY

Group Name	CITY OF GLENDALE
Policy Number	12132192
State of Delivery	ARIZONA
Effective Date	JULY 1, 2011
Policy Term	FORTY-EIGHT (48) 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 INSURANCE COMPANY ("VSP") agrees to insure certain individuals under this Group Vision Care Policy ("Policy") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy 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, including any Exhibits or state-specific Addenda, which are a part of this Policy.

Gary N. Brooks, Secretary

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I.
DEFINITIONS

Key terms used in this Policy are defined:

- 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. **BENEFIT AUTHORIZATION**: Authorization from VSP identifying the individual named a Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled.
- 1.03. **CONFIDENTIAL MATTER**: All confidential information concerning the medical, personal, financial or business affairs of Covered Persons obtained while providing Plan Benefits hereunder.
- 1.04. **COPAYMENTS**: Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
- 1.05. **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 Policy.
- 1.06. **ELIGIBLE DEPENDENT**: Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP in Article VI of this Policy under which such Enrollee is covered.
- 1.07. **EMERGENCY CONDITION**: A condition, with sudden onset and acute symptoms, that requires the Insured to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.
- 1.08. **ENROLLEE**: An employee or member of Group who meets the criteria for eligibility specified under Article VI. ELIGIBILITY FOR COVERAGE.
- 1.09. **EXPERIMENTAL NATURE**: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.
- 1.10. **GROUP**: An employer or other entity which contracts with VSP for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.
- 1.11. **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.

1.12. **GROUP VISION CARE POLICY (also, "THE POLICY")**: The Policy issued by VSP to 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 Policy.

1.13. **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.

1.14. **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.

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

1.16. **RENEWAL DATE**: The date when the Policy shall renew, or terminate if proper notice is given.

1.17. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A to this Policy, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Policy.

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

II.
TERM, TERMINATION, AND RENEWAL

2.01. **Plan Term**: This Policy is effective on the Effective Date and shall remain in effect for the Policy Term. At the end of the Policy Term, the Policy 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 Policy Term that such party is unwilling to renew the Policy. If such notice is given, the Policy shall terminate at 11:59 p.m. on the last day of the Policy Term unless the parties agree on its renewal of the Policy. If the Policy continues on a month to month basis after the Policy Term, either party may terminate the Policy upon thirty (30) days advance notice to the other party.

If VSP issues written renewal materials to Group at least sixty (60) days before the end of the Policy Term and Group fails to accept the new terms and/or rates in writing prior to the end of the Policy Term, this Policy shall terminate at 11:59 p.m. on the last day of the Policy Term.

2.02. **Early Termination Provision**: The Premium rate payable by Group to VSP under this Policy is based on an assumption that VSP will receive these amounts over the full Policy Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Policy Term. If Group terminates this Policy before the end of the Policy Term or before the end of any subsequent renewal terms, for any reason other than material breach by VSP, Group shall be liable for the lesser of any deficit incurred by VSP or the remaining payments which Group would have paid for the full term of this Agreement. 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.

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 who shall be referred to upon enrollment as "Covered Persons." To institute coverage, VSP may require Group to complete, sign and forward to VSP a Group Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums. (Refer to VI. ELIGIBILITY FOR COVERAGE for further details.)

Following the enrollment of the Covered Persons, VSP will provide Group with Member Benefit Summaries for distribution to Covered Persons. Such Member Benefit Summaries will summarize the terms and conditions set forth in this Policy.

3.02. **Provision of Plan Benefits:** Through its Member Doctors (or through other licensed vision care providers where a Covered Person is eligible for, and 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. Benefit Authorization must be obtained prior to a Covered Person obtaining Plan Benefits from a Member Doctor. When a Covered Person seeks Plan Benefits from a Member Doctor, the Covered Person must schedule an appointment and identify himself as a VSP Covered Person so the Member Doctor can obtain Benefit Authorization from VSP. VSP shall provide Benefit Authorization to the Member Doctor to authorize the provision of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Covered Person to obtain Plan Benefits. VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by Group and the Covered Person's 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, irrespective of a later loss of eligibility of the Covered Person, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

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:** Upon request, VSP shall make available to Covered Persons necessary information describing Plan Benefits and how to use them. A copy of this Policy shall be placed with Group and also will be made available at the offices of VSP for any Covered Persons. VSP shall provide Group with an updated list of Member Doctors' names, addresses, and telephone numbers for distribution to Covered Persons twice a year. Covered Persons may also obtain a copy of the Member Doctor directory through contacting VSP's Customer Service Department's toll-free Customer Service telephone line, VSP's Web site at www.vsp.com, or by written request.

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 Policy, including but not limited to sharing information with medical information bureaus, or complying with applicable law. Covered Persons and/or Groups that want more information on VSP's Confidentiality policy may obtain a copy of the policy by contacting VSP's Customer Service Department or VSP's Web site at www.vsp.com.

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 Policy.

IV.
OBLIGATIONS OF THE GROUP

4.01. **Identification of Eligible Enrollees**: An Enrollee is eligible for coverage under this Policy 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 Policy, Group shall provide VSP with eligibility information, in a mutually agreed upon format and medium, to identify all Enrollees who are eligible for coverage under this Policy as of that date. Thereafter, Group shall supply to VSP by the last day of each month, eligibility information sufficient to identify all Enrollees to be added to or deleted from VSP's coverage rosters for the next month. The eligibility information shall include designation of each Enrollee's family status if dependent coverage is provided. Upon VSP's request, Group shall make available for inspection records regarding the coverage of Covered Persons under this Policy.

4.02. **Payment of Premiums**: By the last day of each month, Group shall remit to VSP the premiums payable for the next month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Policy. The Schedule of Premiums incorporated in this Policy as Exhibit B provides the premium amount for each Covered Person. Only Covered Persons for whom premiums are actually received by VSP shall be entitled to Plan Benefits under this Policy 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 on time, VSP may terminate all rights of such Covered Person. Such rights may be reinstated only in accordance with the requirements of this Policy.

VSP may change the premiums set forth in Exhibit B (Schedule of Premiums) by giving Group at least sixty (60) days advance written notice. No change will be made during the Policy Term unless there is a change in the Schedule of Benefits or there is a material change in Policy terms or conditions, provided any such change is mutually agreed upon in writing by VSP and Group.

Notwithstanding the above, VSP may increase premiums during a Policy Term by the amount of any tax or assessment not now in effect but subsequently levied by any taxing authority, which is attributable to premiums VSP received from Group.

4.03. **Grace Period:** Group shall be allowed a grace period of thirty-one (31) days following the premium payment due date to pay premiums due under this Policy. During said grace period, this Policy shall remain in full force and effect for all Covered Persons of Group. VSP will consider late payments at the time of Policy renewal. Such payment may impact Group's premium rates in future Policy Terms.

If Group fails to make any premiums payment due by the end of any grace period, VSP may notify Group that the premiums payment has not been made, that coverage is canceled and that Group is responsible for payment for all Plan Benefits provided to Covered Persons after the last period for which premiums were paid in full, including the grace period through the effective date of termination. Group shall also be responsible for any legal and/or collection fees incurred by VSP to collect amounts due under this Policy.

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

4.05. **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.

V.
OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

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

As conditions of coverage, all Covered Persons under this Policy have the following obligations:

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

5.03. **Authorization of Services**: Benefit Authorization must be obtained prior to receiving Plan Benefits from a Member Doctor. When a Covered Person seeks Plan Benefits, the Covered Person must select a Member Doctor, schedule an appointment, and identify himself as a Covered Person so the Member Doctor can obtain Benefit Authorization from 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 Member Doctor 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. **Submission of Non-Member Provider Claims**: If Non-Member Provider coverage is indicated in Exhibit A (Schedule of Benefits), all claims for services received from Non-Member Providers shall be submitted by Covered Persons to VSP within one hundred eighty (180) days of the date of service. VSP may reject such claims filed more than one hundred eighty (180) days after the date of service.

Failure to submit a claim within this time period, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date of one hundred eighty (180) days after the date of service.

5.05. **Complaints and Grievances**: 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. A Covered Person may submit written comments or supporting documentation concerning his 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.

5.06. **Claim Denial Appeals**: If, under the terms of this Policy, 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 VSP Enrollee's name, the VSP 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 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.

5.07. **Time of Action**: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under this Policy and/or prior to the expiration of sixty (60) days after the claim

and any applicable invoices have been filed with VSP. No such action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoices were submitted to VSP, in accordance with the terms of this Policy.

5.08. **Insurance Fraud**: Any Group and/or person who intends to defraud, knowingly facilitates a fraud or submits an application or files a claim with a false or deceptive statement, is guilty of insurance fraud. Such an act is grounds for immediate termination of the Policy for the Group or individual that committed the fraud.

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 the Group, and

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

(b) **Eligible Dependents:** If dependent coverage is provided, the persons eligible for dependent coverage are:

(1) the legal spouse of any Enrollee, and

(2) any unmarried child of an Enrollee, including any natural child from the moment of birth, or legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; and

(A) for whose support the Enrollee is legally responsible and who has not yet attained the age of 25 years.

(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 remains chiefly dependent on the Enrollee for support and the Enrollee's coverage remains in force; PROVIDED that satisfactory proof of the dependent's incapacity can be furnished to VSP within thirty-one (31) days of the date the Eligible 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) for changes to an Eligible Dependent's status, the change has been reported by the Group to VSP in the manner provided herein. As stated in Paragraph 4.01 above, VSP may elect to audit Group's records in order to verify eligibility of Enrollees and dependents and any errors. Subject to the terms of Paragraph 4.03 above, only persons on whose behalf premiums have been paid for the current period shall be entitled to Plan Benefits hereunder. If a clerical error is made, it will not affect the coverage a Covered Person is entitled under the Policy.

6.03. **Retroactive Eligibility Changes:** Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by VSP. VSP may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

6.04. **Change of Participation Requirements, Contribution of Fees, and Eligibility Rules:** Composition of the Group, percentage of Enrollees covered under the Policy, and Group's contribution and eligibility requirements, are all material to VSP's obligations under this Policy. During the term of this Policy, Group must provide VSP with written notice of changes to its composition, percentage of Enrollees covered, contribution and eligibility requirements. Any change which materially affects VSP's obligations under this Policy must be agreed upon in writing between VSP and Group and may constitute a material change to the terms and conditions of this Policy for purposes of Paragraph 4.02. Nothing in this section shall limit Group's ability to add Enrollees or Eligible Dependents under the terms of this Policy.

6.05. **Change in Family Status:** In the event Group is notified of any change in a Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of Dependent, etc.] Group shall provide notice of such change to VSP via the next eligibility listing required under Paragraph 4.01. If notice is given, the change in the Covered Person's status will be effective on the first day of the month following the change request, or at such later date as may be requested by or on behalf of the Covered Person. Notwithstanding any other provision in this section, a newborn child will be covered during the thirty-one (31) day period after birth, and an adopted child will be covered for the thirty-one (31) day period after the date the Enrollee or Enrollee's spouse acquires the right to control that child's health care. To continue coverage for a newborn or adopted child beyond the initial thirty-one (31) day period, the Group must be properly notified of the Enrollee's change in family status and applicable premiums must be paid to VSP.

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 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.

VIII.
ARBITRATION OF DISPUTES

8.01. **Dispute Resolution:** Any dispute or question arising between VSP and Group or any Covered Person involving the application, interpretation, or performance under this Policy shall be settled, if possible, by amicable and informal negotiations. This will allow 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.

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

8.03. **Choice of Law:** If any matter arises in connection with this Policy which becomes the subject of arbitration or legal process, the law of the State of Delivery of the Policy shall be the applicable law.

IX.
NOTICES

9.01. **Required Notices**: Any notices required to be given under this Policy to either Group or VSP shall be in writing and delivered by United States First Class Mail. Notices sent to Group will be mailed to the address shown on the Group Application. Notices sent to VSP shall be sent to the address shown on this Policy. 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.

X.
MISCELLANEOUS

10.01. **Entire Policy:** This Policy, the Group Application, the Evidence of Coverage, and all Exhibits, Riders and attachments hereto, and any amendments hereto, constitute the entire agreement of the parties and supersedes any prior understandings and agreements between them, either written or oral. Any change or amendment to the Policy must be approved by an officer of VSP and attached hereto to be valid. No agent has the authority to change this Policy or waive any of its provisions. Communication materials prepared by Group for distribution to Enrollees do not constitute a part of this Policy.

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 or employees to perform any of the duties or responsibilities specified herein.

10.03. **Liability:** VSP arranges for the provision of vision care services and materials through agreements with Member Doctors. Member Doctors are independent contractors and responsible for exercising independent judgment. VSP does not itself directly furnish vision care services or supply materials. 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 Policy.

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

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

10.06. **Governing Law:** This Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in compliance with, applicable federal or state statutes or regulations is hereby amended to conform with the requirements of such statutes or regulations, now or hereafter existing.

10.07. **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.

10.08. **Equal Opportunity**: VSP is an Equal Opportunity and Affirmative Action employer.

10.09. **Communication Materials**: Communication materials created by Group which relate to this vision care Policy must adhere to VSP's Member Communication Guidelines distributed to Group by VSP. Such communication materials may be sent to VSP for review and approval prior to use. VSP's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Group's materials meet any applicable legal or regulatory requirements, including, but not limited to, ERISA requirements.

EXHIBIT A

**VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive
Rancho Cordova, California 95670**

**SCHEDULE OF BENEFITS
VSP Choice Plan**

GENERAL

This Schedule lists 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. This Schedule forms a part of the Plan or Policy 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 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 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 \$5.00 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 \$10.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to elective contact lenses.

PLAN BENEFITS

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
VISION CARE SERVICES		
<u>Eye Examination</u>	Covered in Full*	Up to \$ 45.00* ✓

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.

*Less any applicable Copayment.

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* ✓

Available once every 12 months.

Frames

Covered up to Plan Allowance*	Up to \$ 70.00* —
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Available once every 24 months.

*Less any applicable Copayment.

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.

Lens Options

Polycarbonate lenses	Covered in full	Not Covered
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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 Insured's Member Doctor or Non-Member Provider. Prior review and approval by the Company are not required for Insured 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**

Professional Fees and Materials**
Up to \$130.00

Professional Fees and Materials
Up to \$105.00 ✓

*Subject to Copayment

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

LOW VISION BENEFIT

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

	<u>MEMBER DOCTOR BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
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
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Subsequent low vision aids.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is \$1000.00 (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 above for a 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 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 Policy is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Policy 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.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs 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 $\pm .50$ diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Policy which are lost or 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.

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

ADDENDUM

ADDITIONAL BENEFIT RIDER DIABETIC EYECARE PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. Plan Benefits under the Diabetic Eyecare Program ("DEP") are available to Covered Persons who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions, and who are covered under the VSP Signature Plan®. The Diabetic Eyecare Program allows Covered Person's Member Doctor to provide diagnostic services not available under the VSP Signature Plan. The Diabetic Eyecare Program does not cover medical treatment for Covered Persons with diabetic or any other medical conditions.

PROCEDURES FOR OBTAINING DIABETIC EYECARE PROGRAM SERVICES

Covered Person's Member Doctor will provide services under the DEP as needed following Covered Person's routine VSP Signature Plan eye examination. No referrals or authorizations are required for services provided under the DEP.

ELIGIBILITY

Covered Persons under this Program are the same as stated in Section VI of this Policy.

COPAYMENT

A Copayment of \$20.00 is required for each Ophthalmological Service and Office Visit under the DEP, and is paid to the Member Doctor at the time of service. Other Copayments may apply to services under Covered Person's VSP Signature Plan. Refer to the VSP Signature Plan Schedule of Benefits associated with this Rider.

EXHIBIT B

**VISION SERVICE PLAN INSURANCE COMPANY
3333 Quality Drive
Rancho Cordova, California 95670**

**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:

- \$ 6.40 ✓ per month for each eligible Enrollee without Eligible Dependents.
- \$ 14.26 ✓ per month for each eligible Enrollee (includes coverage for Eligible Dependents).

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

PLAN BENEFITS

SERVICE*	MEMBER DOCTOR BENEFIT	BENEFIT FREQUENCY†	
Ophthalmological services and Office Visits	Covered in full, less \$20.00 Copayment	Once every 12 months	
Gonioscopy	Covered in full	Once every 12 months	
Extended Ophthalmoscopy	Covered in full	Once every 6 months*	
Fundus Photography	Covered in full	Once every 6 months*	
COVERED SERVICES (The following list is current as of [7/1/08] and is subject to change without notice.)			
Description	Procedure Code		
Ophthalmological services	92002, 92004, 92012, 92014		
Office Visits	99201 - 99205, 99211 - 99215		
Gonioscopy	92020		
Extended Ophthalmoscopy	92225, 92226		
Fundus Photography	92250		
*Service and/or diagnosis limitations apply, or certain procedures require special handling. Member Doctors must consult the <i>VSP ProviderReference Manual</i> for details before rendering services.			
†Benefit frequency periods begin on the date of the first Ophthalmological Service or Office Visit.			

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The DEP covers diabetic eyecare evaluation services only. There is no coverage provided under the Plan for the following:

- Costs associated with securing frames, lenses or any other materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical procedures, including Laser or any other form of refractive surgery, and any pre- or post-operative services.
- Pathological treatment of any type for any condition.
- Any eye examination required by an employer as a condition of employment.
- Insulin or any medications or supplies of any type.
- Services and/or materials not included in this Rider as covered Plan Benefits.

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 makes insufficient insulin or can't efficiently use it.
Fundus Photography	Taking photos of the inside of the eye that show the optic nerve and retinal vessels.
Extended Ophthalmoscopy	A method of examining the posterior of the eye, including a true drawing of the retina accompanied by an interpretation and plan.
Gonioscopy	Use of a special contact lens to look at the eye's aqueous drainage area.

VISION SERVICE PLAN INSURANCE COMPANY

AMENDMENT TO GROUP VISION CARE POLICY

This Addendum shall be attached to and made a part of Group Vision Care Policy Number 12132192 ("Policy"), issued by VISION SERVICE PLAN INSURANCE COMPANY to CITY OF GLENDALE.

EXCEPT as otherwise specifically stated herein, all terms and conditions of said Policy remain unchanged and are in full force and effect.

IT IS HEREBY AGREED that effective JULY 1, 2011, the Group Vision Care Policy shall be revised to include an Administrative Services Program for the Safety and Repair/Replacement benefits as outlined on the attached Safety Eyewear Addendum and the Repair/Replacement Addendum.

IT IS FURTHER AGREED that the Policy shall be amended as it pertains to the Administrative Services Program Safety and Repair/Replacement benefits as follows.

1. Section I. Definitions, the following shall be added:

Claims Amount: Total charges for benefits delivered, including the cost of professional services and ophthalmic materials, charges for VSP services related to materials purchased, and taxes.

2. Section 4.02, Payment of Premiums shall be revised to include the following:

- (a) **Claims Amounts and Advance of Payment:** Group shall provide all funds necessary to pay the Claims Amount associated with the Administrative Services Program for the Safety and Repair/Replacement benefits. In order to assure timely and adequate payment, Group agrees to make an Advance Payment as outlined on the attached Schedule of Advance Payment and Administrative Fees, Exhibit B. This Advance Payment is an estimate of the Claims Amount for one (1) month. Group agrees to pay the actual Claims Amounts on a monthly basis within ten (10) days after receipt of VSP's statement. The Advance Payment amount may be adjusted each Plan Term if the average of monthly Claims Amount increases or decreases. The parties agree that such Advance Payment is reimbursable to the Group upon termination of this Plan, after the Group's indebtedness to VSP and/or its benefit providers has been satisfied. However, amounts paid to VSP as Advance Payment shall not be considered assets of the Group, and need not be held in trust by VSP.

Administrative Fee: Additionally, on or before the first day of each month, Group shall remit to VSP an Administrative Fee as outlined on the attached Schedule of Advance Payment and Administrative Fee, Exhibit B. Change will not be made to the Administrative Fee during any Plan Term unless there is a change in the Schedule of Benefits or a material change in any other terms and conditions of the Plan, provided any such change is mutually agreed upon in writing between VSP and Group.

Notwithstanding the above, VSP reserves the right to increase amounts due hereunder during a Plan Term 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 amount due VSP from Group.

3. Section 4.03, Grace Period, the following shall be added:

Grace Period: Group shall be allowed a grace period of thirty-one (31) days following the due date for making any payment of amounts due under this Plan. During the grace period, this Plan will remain in full force and effect for all Covered Persons. Late payments will be considered by VSP at the time of Plan renewal and may impact Group's Advance Payment and Administrative Fees in future Plan Terms.

If Group fails to make any payment of amounts due by the end of any grace period, VSP may notify Group that the payment of amounts due has not been made, that coverage is canceled and that the Group is responsible for payment for the Claims Amount associated with Plan Benefits provided to Covered Persons after the last period for which amounts due were fully paid, including the grace period and through the effective date of the termination. Group shall also remain responsible for payment, in accordance with Paragraph 2.02, of any Claims Amount associated with Benefit Authorizations outstanding at the time of termination, and for any legal and/or collection fees incurred by VSP in collecting amounts due under this Plan.

4. Section 6.04, Retroactive Eligibility Changes, the following shall be added:

Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by VSP. If coverage is retroactively terminated for an individual, Group shall remain responsible for the Claims Amount associated with any Plan Benefits provided to that individual pursuant to the Benefit Authorization issued by VSP in reliance on the latest eligibility information available to VSP at the time of such Benefit Authorization.

IT IS FURTHER AGREED that the attached Exhibit B shall be added to the Agreement as it pertains to the Administrative Services Program for the Safety and Repair/Replacement benefits.

Gary N. Brooks, Secretary

ADDENDUM

ADDITIONAL BENEFIT RIDER SAFETY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. This Rider forms a part of the Plan or Certificate of Coverage to which it is attached.

COVERED PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS OUTLINED UNDER ARTICLE VI. OF THE GROUP VISION CARE PLAN AND WHO REQUIRE SAFETY EYEWEAR DUE TO THE NATURE OF THEIR WORK SHALL BE ELIGIBLE FOR THE SAFETY EYECARE PLAN.

ELIGIBILITY

The following are Covered Persons under this Plan.

- Enrollee.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated:

COPAYMENT

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

There shall be no Copayment payable by the Covered Person to the Member Doctor at the time services are rendered.

PLAN BENEFITS

<u>SERVICE OR MATERIAL</u>	<u>MEMBER DOCTOR BENEFIT</u>
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Eye Examination	Covered in full*
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A Limited Level supplemental vision analysis of the eyes and related structures that addresses the specific visual needs relative to Safety EyeCare. Refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section for additional details.

Subsequent regular eye examinations every 12 months beginning with the first date of service.

*Less any applicable Copayment.

<u>SERVICE OR MATERIAL</u>	<u>MEMBER DOCTOR BENEFIT</u>
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Lenses	Covered in full*
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Member Doctors shall ensure that lenses provided under the Safety EyeCare Plan meet the following minimum standards:

- Be no less than 3mm at the thinnest point.
- Be impact-tested with a one-inch steel ball dropped from a height of 50 inches.
- Be engraved by the manufacturer that it is a safety lens.

Available once every 12 months beginning with the first date of service.

*Less any applicable Copayment.

<u>SERVICE OR MATERIAL</u>	<u>MEMBER DOCTOR BENEFIT</u>
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Lens Options

Polycarbonate lenses	Covered in full
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SERVICE OR MATERIAL

MEMBER DOCTOR BENEFIT

Frames

Covered up to Plan Allowance*

Member Doctors shall ensure that frames provided under the Safety EyeCare Plan meet the following minimum standards:

- Have a "Z-87" stamp on the front and temples.
- Be fabricated of a slow-burning material.
- Have the manufacturer's logo imprint.
- Be constructed so that, if impacted from the front, the lens will not come out through the back of the frame.

Materials will be certified as safe for a work environment by meeting the required test standards as set forth by the American National Standards Institute (ANSI).

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

Available once every 24 months beginning with the first date of service.

*Less any applicable Copayment

EXCLUSIONS AND LIMITATIONS OF BENEFITS

SAFETY EYECARE PLAN

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 vision service plan 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 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.
- Lens laminations.
- 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.

NOT COVERED

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

- Subnormal vision aids.
- Orthoptics or vision training and any associated supplementary testing not specifically related to Safety EyeCare.
- Plano lenses.
- *Two pair of glasses in lieu of bifocals.*
- Contact lenses.
- 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.
- Corrective vision treatment of an Experimental Nature.
- Examinations above a Limited Level unless the Covered Person: (i) is not eligible for an eye examination under the Plan to which this Rider is attached; (ii) received an eye examination from another Member Doctor during the same eligibility period; or (iii) received an eye examination during the preceding 6 months from a practitioner in the same Member Doctor's office that will be providing the Safety EyeCare examination.
- Rimless frames.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.
- Services and/or materials received from a Non-Member Provider.

EXHIBIT C

ADDITIONAL BENEFIT RIDER REPAIR/REPLACE BENEFITS

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") 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. This Rider forms a part of the Plan and Evidence of Coverage to which it is attached.

Repair/Replace Benefits provide coverage for materials obtained when the Covered Person is not eligible for materials under the Schedule of Benefits to which this Rider is attached. Covered Persons are eligible if their spectacle lenses or frame are broken or damaged and in need of repair or replacement.

Persons covered under this additional benefit may be entitled to eyeglass frame repairs, which shall include but not be limited to temples only, front only, hinge and miscellaneous repairs; or replacement of complete frame and single vision and multifocal lens repair or replacement.

ELIGIBILITY

The following are Covered Persons under this Plan:

- Enrollee

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

COPAYMENT

There shall be no Copayment payable by the Covered Person to the Member Doctor at the time services are rendered.

SERVICES FROM MEMBER DOCTORS

PLAN BENEFITS

VSP may authorize payment under this Rider for materials for Covered Persons more frequently than 12 months if

1. Eyeglass frames are broken or damaged, which shall include but are not limited to temples only, front only, hinge and miscellaneous repairs. Replacement of complete frame may be covered if frame is damaged beyond repair.
2. Single vision and multifocal lens require repair or replacement.

SERVICE OR MATERIAL	MEMBER DOCTOR BENEFIT	FREQUENCY
Lenses	Refer to Schedule of Benefits	Available once each 12 months**
Frames	Refer to Schedule of Benefits	Available once each 12 months**
<p>VSP reserves the right to limit the cost of the frames provided by its Member Doctors under the Plan. The current allowance shall be published periodically by VSP to its Member Doctors and will be set at a level to cover a sufficient number of frames in common use.</p> <p>If the Covered Person wishes to select a more expensive frame than that allowed under this Rider, the cost difference shall be by agreement between the Covered Person and Member Doctor.</p> <p>Plan Benefits for lenses are per complete set, not per lens.</p>		

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.

REPAIR/REPLACE BENEFIT ONLY

NOT COVERED

There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
3. Two pair of glasses in lieu of bifocals.
4. Medical or surgical treatment of the eyes.
5. Corrective vision treatment of an Experimental Nature.
6. Services or materials of a cosmetic nature.
7. Costs for services and/or materials exceeding Plan Benefit allowances.
8. Services and/or materials not indicated on this Rider as covered Plan Benefits.
9. Services and/or materials received from a Non-Member Provider

EXHIBIT B

**ADVANCE PAYMENT AND ADMINISTRATIVE FEES
SAFETY EYECARE PLAN & REPAIR/REPLACEMENT PLAN**

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

Advance Payment

Waived

Administrative Fee

Safety Eyecare Plan:

19% OF MONTHLY CLAIMS AMOUNT

Repair/Replacement Plan:

20% OF MONTHLY CLAIMS AMOUNT

Said Advance payment and Administrative Fee(s) shall be guaranteed for a period of FORTY-EIGHT (48) months through JUNE 30, 2015.

NOTICE: The Advance Payment and Administrative Fee 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 change in any other terms or conditions of the Plan.

AMENDMENT

VISION SERVICE PLAN INSURANCE COMPANY

**PLEASE ATTACH TO YOUR
GROUP VISION CARE AGREEMENT**

AMENDMENT TO GROUP VISION CARE AGREEMENT

To be attached to and made part of Group Vision Care Agreement, issued to CITY OF GLENDALE, 12132192.

EXCEPT as specifically amended herein, said Agreement shall remain in full force and effect.

IT IS HEREBY AGREED that effective JULY 1, 2011, the Group Vision Care Agreement shall be amended as follows:

Section 2.02 **Early Termination Provision** is removed in its entirety.

Section 10.09 **Communication Materials** has been revised as follows:

10.09. **Communication Materials**: Communication materials created by Group which relate to this vision care Policy must adhere to VSP's Member Communication Guidelines distributed to Group by VSP. Such communication materials may be sent to VSP for review and approval prior to use. VSP's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that Group's materials meet any applicable legal or regulatory requirements.

CITY OF GLENDALE, an Arizona
municipal corporation



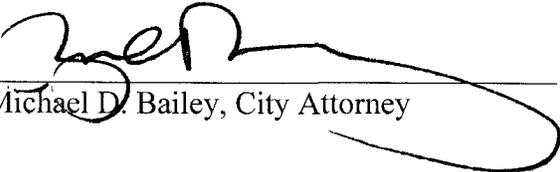
Brenda S. Fischer, City Manager

ATTEST:



Pamela Hanna, City Clerk (SEAL)

APPROVED AS TO FORM:



Michael D. Bailey, City Attorney