THIRD
AMENDMENT TO AGREEMENT
With
VISION SERVICE PLAN INSURANCE COMPANY

THIS THIRD AMENDMENT to Agreement ("Third Amendment") is made and entered into by and between the City and County of Denver, a municipal corporation of the State of Colorado ("City"), and Vision Service Plan Insurance Company ("VSP"), whose address is 3333 Quality Drive, Rancho Cordova, California 95670 (the "Consultant"), jointly "the parties".

WITNESSETH:

WHEREAS, the parties entered into an Agreement dated August 02, 2019, Contract number CSAHR-201948822-00 ("Agreement") and thereafter amended it as follows: First Amendment (CSAHR-201952645-01), and Second Amendment (CSAHR-201952645-02); and

WHEREAS, the parties desire to extend the term of the Agreement, increase the maximum contract amount and add the attached 2025 summary of coverage to the existing Exhibit A through this Third Amendment.

NOW, THEREFORE, in consideration of the premises, the mutual agreements herein contained, and subject to the terms and conditions hereinafter stated, the Parties agree as follows:

1. The first sentence of Article 3 of the Agreement entitled **Term** is hereby amended to read as follows:

> "**3.** **<u>TERM</u>:** The Agreement will commence January 01, 2019 and shall expire at 11:59 p.m. on December 31, 2025 (the "Term")."

2. Paragraph 4 of the Agreement entitled <u>"MAXIMUM CONTRACT AMOUNT"</u> is hereby deleted and restated as follows:

> "**4. <u>MAXIMUM CONTRACT AMOUNT</u>**. The maximum contract amount to be paid for the underlying insurance policies referenced herein, shall in no event exceed **SEVEN MILLION DOLLARS AND NO CENTS ($7,000,000.00)**, (the "Maximum Contract Amount")."

3. The attached 2025 plan information shall be added to the existing Agreement as part of Exhibit A.

4. This Amendatory Agreement may be executed in counterparts, each of which shall be deemed to be an original, and all of which, taken together, shall constitute one and the same instrument.

5. Except as herein amended, the Agreement is affirmed and ratified in each and every particular.

Contract Control Number: CSAHR-201952645-03 [201948822-03]
Contractor Name: Vision Service Plan Insurance Company (VSP) Insurance Company (VSP)

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of:

SEAL

CITY AND COUNTY OF DENVER:

ATTEST:

By: ______________________________

____

APPROVED AS TO FORM:

Attorney for the City and County of Denver

By: ______________________________

REGISTERED AND COUNTERSIGNED:

By: ______________________________

By: ______________________________

Contract Control Number: CSAHR-201952645-03 [201948822-03]
Contractor Name: Vision Service Plan Insurance Company (VSP)

By: ____

Name: Usha Patil______________________________
(please print)

Title: Chief Insurance Officer___________________
(please print)

ATTEST: [if required]

By: ____

Name: ______________________________________
(please print)

Title: ______________________________________
(please print)

VISION SERVICE PLAN INSURANCE COMPANY

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2025 Plan Information

A Look at Your VSP Vision Coverage

With VSP and City and County of Denver, your health comes first.

Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

With private practice doctors and Visionworks retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

VSP EasyOptions

Each member on your plan can personalize their benefit with ease. Choose the upgrade that's right for you! Check out the plan grid to see your options.

More Ways to Save

Extra

$20

to spend on Featured Frame Brands†

bebe | Calvin Klein
COLE HAAN | DRAGON
FLEXON | LONGCHAMP PARIS

and more

See all brands and offers at **vsp.com/offers**.

Up to

40%

Savings on lens enhancements‡

Enroll through your employer today.

Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

City and County of Denver and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
01/01/2025

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME[+]	• $180 Featured Frame Brands allowance • $160 frame allowance • 20% savings on the amount over your allowance • $90 Walmart/Costco frame allowance	Included in Prescription Glasses	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $160 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
VSP EASYOPTIONS[†]	**Members can choose one of these upgrades** • An additional $90 frame allowance, or fully covered premium or custom progressive lenses, or fully covered light-reactive lenses, or fully covered anti-glare coating, or an additional $40 contact lens allowance	Included in Prescription Glasses	Every calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average of 15% off the regular price; discounts available at contracted facilities. **Exclusive Member Extras for VSP Members** • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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VSP, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare and VSP Premier Edge are trademarks of Vision Service Plan. Flexon and Dragon are registered trademarks of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners. 102898 VCCM

Classification: Restricted

October 22, 2024

BARBARA OLMER
8110 E UNION AVE STE 100
DENVER, CO 80237-2966

RE: CITY AND COUNTY OF DENVER, GROUP #30050633, PLAN

Attention Barbara Olmer:

Effective JANUARY 1, 2025, CITY AND COUNTY OF DENVER's contract has been changed to reflect an additional benefit

Please retain a copy of the documents for your records and forward an additional copy directly to the client.

If you have any questions, or need additional information, please do not hesitate to contact us at 866-213-2249, and a VSP representative will assist you.

Enclosures

These documents are intended only for the client to whom they are addressed and may contain confidential information. If you are not the intended recipient (or the person responsible for delivering it to the intended recipient) and have received these documents in error, please notify the sender immediately by telephone, and destroy or delete these document

P.O. Box 997100, Sacramento, CA 95670-7985 | P: 916.635.7373 800.877.7195 | vsp.com

VISION SERVICE PLAN INSURACE COMPANY

PLEASE ATTACH TO YOUR

CLIENT VISION CARE POLICY

AMENDMENT TO CLIENT VISION CARE POLICY

This Amendment (herein "Amendment") to the Client Vision Care Policy Number 30050633 issued to CITY AND COUNTY OF DENVER (herein "Policy") is effective as of January 1, 2025.

IT IS HEREBY MUTUALLY AGREED by the Parties that the Policy is amended as follows:

1. **Amendment to the Policy.**

1. **Amendment to Policy Period**. The Policy Period (or Policy Term) which appears on the cover page of the Policy is hereby extended for 48 (Forty-Eight) months.

   a. **Amendment of Exhibit A.** Exhibit A is hereby replaced in its entirety with the attached Exhibit A.

   b. **Amendment of Exhibit B.** Exhibit B is hereby replaced in its entirety with the attached Exhibit B.

2. **Miscellaneous.**

   a. **No Other Changes.** Except as specifically modified in this Amendment, all terms of the Policy shall remain in full force and effect.

VISION SERVICE PLAN INSURANCE COMPANY

By: [signature]

Printed Name: Usha Patil

Title: Chief Insurance Officer

DATE: OCTOBER 22, 2024

EXHIBIT A

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
VSP Choice Plan®

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy 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
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of Enrollee, including a 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 or administrative agency holds the Enrollee responsible.

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.

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames, or Necessary Contact Lenses) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

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

Standard Progressive Lenses covered in full.

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

The VSP PREFERRED Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses are covered up to $160.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months, after a $60.00 Copayment.

NECESSARY

Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP PREFERRED Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**Beginning every January 1st.

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to choose one of the following EasyOptions upgrades:

FRAMES: An Additional Allowance of $90.00 once every 12 months**
OR
LENS ENHANCEMENT
Premium and Custom Progressive lenses: Covered in full once every 12 months**
OR
LENS ENHANCEMENT
Photochromic: Covered in full once every 12months**
OR
LENS ENHANCEMENT
Anti-reflective coating: Covered in full once every 12 months**
OR
CONTACT LENSES
ELECTIVE: An Additional Allowance of $ 40.00 once every 12 months**

*Less any applicable Copayment.
**Beginning every January 1st.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP PREFERRED Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP PREFERRED Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

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

NOT COVERED

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

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames, or Necessary Contact Lenses) are provided, there shall be an additional $25.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $ 30.00* once every 12 months**

Bifocal Up to $ 50.00* once every 12 months**

Trifocal Up to $ 65.00* once every 12 months**

Lenticular Up to $100 .00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 12 months**

CONTACT LENSES

ELECTIVE
Elective Contact Lenses are covered up to $145.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

NECESSARY
Necessary Contact Lenses are covered up to $ 210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
** beginning every January 1st.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Open Access Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP PREFERRED Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP PREFERRED Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP PREFERRED Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT B

VISION SERVICE PLAN INSURANCE COMPANY
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.

$ 9.54 per month for each eligible Enrollee without dependents
$ 19.41 per month for each eligible Enrollee with an eligible spouse
$ 17.90 per month for each eligible Enrollee with eligible child(ren)
$ 32.72 per month for each eligible Enrollee with eligible spouse and child(ren)

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.

EXHIBIT C

VISION SERVICE PLAN INSURANCE COMPANY
ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE

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. The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment, and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes. This Rider forms a part of the Policy and 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
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of Enrollee, including a natural child from date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible. A child also includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth.

Dependent children are covered up to the end of the month in which they turn 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.

Essential Medical Eye Care benefits are available to Covered Persons only after covered benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered benefits include specific medical eye care procedure codes when appropriate for the optometric scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine available benefits and how to obtain medical plan benefits.

The eye care provider should first submit a claim to Covered Person's group medical plan when participating in the medical plan's network. Any amounts not paid by the primary medical plan may then be considered for payment by VSP. This process is referred to as Coordination of Benefits ("COB."). Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, or when a VSP Preferred Provider does not participate with Covered Person's group medical plan, the Supplemental Essential Medical Eye Care provides plan benefits as follows:

1. Covered Person contacts Member Doctor and makes an appointment.

2. Covered Person pays the applicable Copayment at the time Supplemental Essential Medical Eye Care services are rendered and amounts for any additional services not covered by the Plan.

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COVERED SERVICES

Medical Eye Examinations: Covered in Full after a Copayment of $20.00.
Urgent/Emergency Care* and Special Ophthalmological Services:** Covered in Full

*Urgent/Emergency Care refers to VSP covered services for an emergency medical eye condition including, but not limited to eye infections, foreign body and abrasions, ocular injuries, and chemical exposure to the eye or eyelid.

**Special Ophthalmological Services refer to eye care services that are problem-focused and involve medical decision-making. Special ophthalmological services go beyond general services and relate to the diagnosis, evaluation, treatment, and management of ocular conditions.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Supplemental Essential Medical Eye Care provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to the Client upon request.

NOT COVERED

1. Eyeglasses or contact lenses.
2. General anesthesia surgical procedures.
3. Preoperative or postoperative surgical procedures.
4. Inpatient hospital services.
5. Services provided for refractive diagnoses that are part of the Covered Person's routine vision care coverage.
6. Prescription medication or supplies of any type.
7. Local, state and/or federal taxes, except where VSP is required by law to pay.
8. Services and/or materials not specifically included in this Rider as covered Plan Benefits.