

**AMENDMENT NO. 1**  
**RFP NO. 604355-17**  
**VISION CARE SERVICES FOR THE SELF-FUNDED BENEFIT PLAN**

**THIS AMENDMENT** is made and entered into this \_\_\_\_\_ day of \_\_\_\_\_ 2021, by and between CLARK COUNTY, NEVADA (hereinafter referred to as "COUNTY"), and EYEMED VISION CARE, LLC (hereinafter referred to as "PROVIDER").

**WITNESSETH:**

**WHEREAS**, the parties entered into an agreement under RFP Number 604355-17, entitled "Vision Care Services for the Self-Funded Benefit Plan" dated September 29, 2017 (hereinafter referred to as CONTRACT); and

**WHEREAS**, the parties desire to amend the CONTRACT.

**NOW, THEREFORE**, the parties agree to amend the CONTRACT as follows:

1. Exhibit A; add pages A-6 through A-11 attached to this Amendment No. 1.
2. Fidelity Security Life Insurance Company insurance documents referenced as "Application for Vision Care Benefits" and "Your Custom Vision Quote" shall be added in their entirety as attached hereto.
3. The revisions contained herein are effective as of January 1, 2022.

Except as expressly amended herein, the terms and conditions of the CONTRACT shall remain in full force and effect.

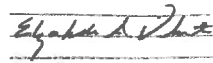
COUNTY  
COUNTY OF CLARK, NEVADA

PROVIDER:  
EYEMED VISION CARE, LLC

By: \_\_\_\_\_  
JESSICA COLVIN  
Chief Financial Officer

By:  \_\_\_\_\_  
NATASHA D'SA  
VP Sales & Account Management

**APPROVED AS TO FORM:**  
STEVEN B. WOLFSON, District Attorney

By:  \_\_\_\_\_  
ELIZABETH VIBERT  
Deputy District Attorney

Reviewed As to Form by EyeMed Legal:



**EXHIBIT A  
VISION CARE SERVICE FOR THE SELF-FUNDED BENEFIT PLAN  
SCOPE OF WORK**

**EPO VISION PLAN**

**I: GENERAL REQUIREMENTS**

- A. PROVIDER shall, but not limited to, provide vision benefits as set forth herein to eligible officers, retirees, employees, and dependents, as defined by the Clark County Self-Funded EPO Plan Document adopted by the governing bodies of the entities comprising the GROUP.
- B. Provide an appeal mechanism for COVERED PERSONS as set forth below, Claims Appeal Procedures, incorporated herein by this reference:
  - a) COMPLAINTS - BENEFIT ELIGIBILITY
    - 1. If an in-network claim is denied, PROVIDER will work with the physician/facility to explain the reason for denial and outline necessary steps to resolve the denial.
    - 2. If an out-of-network claim for benefits is denied, PROVIDER will notify the claimant in writing of the specific reasons for the denial, including specific references to pertinent Plan provisions. PROVIDER will also describe any additional materials or information necessary. This will also include information on how to contact the Customer Care Center at 1-866-723-0513 in the event the member needs to talk through the claim denial and next steps.
    - 3. If the claimant, or the duly authorized representative, so requests within one hundred eighty (180) days of the date of receipt of written denial of the claim, PROVIDER will review the decision denying the claim.
    - 4. PROVIDER will give the claimant a reasonable opportunity for a full and fair review of the decision denying the claim. The claimant will be given the opportunity to review pertinent documents, and to submit any statements, documents, or written arguments in support of this claim.
  - b) COMPLAINTS - PROFESSIONAL SERVICES
    - 1. The COVERED PERSON should contact the EyeMed Customer Care Center to request resolution. If the COVERED PERSON is not satisfied with the resolution from the Customer Care Center, they can file a written complaint with EyeMed's Quality Assurance Department. They can also include written comment or supporting documentation.
    - 2. The EyeMed Quality Assurance Department will resolve the complaint within thirty (30) days after receipt unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.
- C. Remain responsible for furnishing vision care benefits to patients of any of PROVIDER'S providers who leave its plan for any reason, either through the provider or, at the election of PROVIDER, through another of PROVIDER'S providers.

- D. Collect and analyze vision care data relative to services provided to the GROUP and provide periodic statistical information regarding utilization to COUNTY.
- E. Provide the GROUP with an initial supply of 3,000 to 6,000 copies of PROVIDER'S List of Member Doctors and an additional supply of 3,000 to 6,000 copies in support of the GROUP'S annual open enrollment mailing.

## II. DEFINITIONS

- A. Anisometropia: A condition of unequal refractive state for the two eyes, one eye. Requiring a different lens correction than the other.
- B. Benefit Form: A form prepared for a COVERED PERSON who has received approval of service from PROVIDER.
- C. Blended Lenses: Bifocals which do not have a visible dividing line.
- D. Claim: A benefit form which has been presented to a member or non-member Provider at the time the COVERED PERSON secures services.
- E. Coated Lenses: A substance added to a finished lens on one or both surfaces.
- F. Covered Person: An eligible officer, employee, retiree or dependents enrolled in the Clark County Self-Funded EPO Plan.
- G. Group: The Clark County Self-Funded EPO Group Insurance Program.
- H. Keratoconus: A developmental or dystrophic deformity of the cornea in which it becomes cone shaped due to thinning and stretching of the tissue in its central area
- I. Materials: Lenses, frame, low vision aids, contact lenses
- J. Orthoptics: The teaching and training process for the improvement of visual perception and coordination for the two eyes for efficient and comfortable binocular vision.
- K. Oversize Lenses: Larger than standard lens blanks to accommodate prescriptions.
- L. Photo Chromic Lenses: Lenses which change color with intensity of sunlight.
- M. Plano Lenses: Lenses which have no refractive power.
- N. Professional Service: Examination, material selection, fitting of glasses, related adjustments, etc.
- O. Tinted Lenses: Lenses, which have an additional substance, added to produce constant tint (e.g., pink, green, gray, blue, etc.)

## III. SERVICES FROM VISION PLAN MEMBER DOCTORS

### A. CHOICE OF PROVIDERS

PROVIDER Plan provides COVERED PERSONS with a dual choice. If the COVERED PERSON elects to receive vision care services from a PROVIDER Member Doctor, PROVIDER is a PREPAID program and covered services are provided with the COVERED PERSON responsible for the following cost sharing amounts:

1. Ten dollars (~~\$10.00~~) for the examination payable by the COVERED PERSON to the Member Doctor at the time of the examination.
2. Zero dollars (~~\$0.00~~) for any required materials payable by the COVERED PERSON at the time the materials are ordered except that the deductible for materials shall not apply to elective contact lenses.

### B. VISION EXAMINATION

A complete analysis of the eyes and related structures will be provided to determine the presence of vision problems or other abnormalities.

Each COVERED PERSON shall be entitled to a vision examination once each twelve (12) months.

### C. MATERIALS

Where the vision examination indicates that new lenses or frames or both are necessary for the proper visual health and welfare of a COVERED PERSON, they will be supplied, together with such professional services as are necessary, which shall include, but not be limited to:

- Prescribing and ordering proper lenses
  - Assisting in the selection of a frame
  - Verifying the accuracy of the finished lenses
  - Proper fitting and adjustment of the spectacles
1. LENSES: The PROVIDER Member Doctor will order the proper lenses necessary for the COVEREDPERSON'S visual welfare.
  2. FRAMES: New frames will be provided once each twenty-four (24) months.

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

IF THE COVERED PERSON WISHES TO SELECT A MORE EXPENSIVE FRAME THAN THAT ALLOWED UNDER THE PROGRAM, THE COST DIFFERENCE SHALL -BE BY AGREEMENT BETWEEN THE COVERED PERSON AND THE DOCTOR.

3. CONTACT LENSES - LIMITATIONS:

Necessary

Contact lenses are furnished under the PROVIDER Plan when the PROVIDER Member Doctor secures prior approval for any of the following conditions:

- a. Following cataract surgery
- b. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
- c. Certain conditions of Anisometropia
- d. Keratoconus

When PROVIDER Member Doctor receives prior approval for such cases, they are fully covered by PROVIDER and are IN LIEU OF THOSE BENEFITS DESCRIBED UNDER "C. MATERIALS".

CONTACT LENSES ONCE FURNISHED UNDER THIS PLAN AS DESCRIBED ABOVE CAN BE REPLACED ONLY WITH PRIOR AUTHORIZATION BY PROVIDER, BUT IN NO EVENT MORE FREQUENTLY THAN EVERY TWENTY-FOUR (24) MONTHS.

Elective

When a COVERED PERSON chooses contact lenses from a PROVIDER Member Doctor for reasons other than those outlined above, PROVIDER will provide benefits as follows: The initial basic examination will be covered in full as described under "B. VISION EXAMINATION", and an allowance will be paid toward contact lens evaluation fee, fitting costs and materials in lieu of those benefits described under "C. MATERIALS".

D. FACILITIES

This vision care plan is an agreement among, various state vision service corporations throughout the United States. Through these service plans and their extensive nationwide network of doctors, PROVIDER provides professional vision care to employees and dependents covered under group vision care plans.

A list of Member Doctors in the COVERED PERSON'S geographical location will accompany the benefit form sent to the COVERED PERSON upon verification of their eligibility. This list contains the names, addresses and telephone numbers of the Member Doctors. If this list

does not cover the geographical area in which the COVERED PERSON desires to seek services, the COVERED PERSON may call or write PROVIDER office nearest him to obtain one which does.

E. SERVICES FROM NON-MEMBER PROVIDER

1. LIABILITY OF COVERED PERSON FOR 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. PROVIDER 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 DEDUCTIBLE EXCEPT AS NOTED ELSEWHERE HEREIN AS THOSE DESCRIBED FOR SERVICES FROM MEMBER DOCTORS. SERVICES OBTAINED FROM A NON-MEMBER PROVIDER ARE IN LIEU OF OBTAINING SERVICES FROM A PANEL MEMBER OF PROVIDER.

2. MAXIMUM REIMBURSEMENT FOR SERVICES FROM NON-MEMBER PROVIDER

PROFESSIONAL FEES

Vision Examination, up to \$ 40.00

MATERIALS      PAIR

Single Vision Lenses, up to \$ 30.00

Bifocal Lenses, up to \$ 50.00

Trifocal Lenses, up to \$ 70.00

Lenticular Lenses, up to \$ 70.00

Frame, up to \$ 42.00

CONTACT LENSES\*

(Materials, Fittings and Evaluation Only)

Necessary, up to \$ 210.00

Elective, up to \$ 80.00

\*Determination of "necessary" versus "elective" contact lenses under the non-member reimbursement schedule will be consistent with Member Doctor services. Reimbursement allowance for necessary and elective contact lenses includes contact lens evaluation fee, fitting costs and materials and is in lieu of all other material benefits, including spectacle lenses and frame.

THE AMOUNTS SHOWN ARE MAXIMUMS. THE ACTUAL AMOUNT TO BE PAID IN REIMBURSEMENT TO THE COVERED PERSON SHALL BE THE MAXIMUM SHOWN IN THE SCHEDULE OF SERVICE, THE AMOUNT CHARGED, OR THE AMOUNT USUALLY CHARGED BY THE PROVIDER OF SUCH SERVICES TO HIS PRIVATE PATIENTS, WHICHEVER IS DETERMINED BY PROVIDER TO BE THE LEAST AMOUNT

F. REIMBURSEMENT BENEFITS ARE NOT ASSIGNABLE

PROCEDURES FOR USING THE PLAN

1. A COVERED PERSON must receive an approval of service before visiting a Member Doctor. Such approval is obtained from PROVIDER.
2. The COVERED PERSON will be provided a list of Member Doctors and will make an appointment with a Member Doctor of their choice.
3. The COVERED PERSON pays only the deductible (if any) to the doctor for the services covered by the Plan and for any additional services received not covered by the Plan. PROVIDER will pay the Member Doctor directly according to their agreement with the doctor.
4. Should the Covered Person receive services from a Member Doctor without such approval or obtain services from a provider who is not a PROVIDER Member Doctor, the COVERED PERSON is responsible for payment in full to the provider.
5. When such approval is received by a COVERED PERSON and services are performed prior to the expiration date shown on the approval, this will constitute a claim against the Plan in spite of the COVERED PERSON'S termination of coverage or the termination of the Plan.
6. In emergency cases, when immediate vision care is necessary, a COVERED PERSON can obtain covered services by contacting a PROVIDER Member Doctor. Reimbursement will be made in accordance with the agreement between PROVIDER and the Member Doctor.
7. PROVIDER reserves the right to reject any and all claims for services or benefits, which are filed with it more than one hundred eighty (180) days after completion of services.

G. EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. PATIENT OPTIONS

This 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, and the COVERED PERSON will pay the additional costs for the options.

- a. Contact lenses (except as noted elsewhere herein).
- b. Oversize lenses.
- c. Photo chromic lenses.
- d. Progressive multi focal lenses.
- e. The coating of the lens or lenses.
- f. The laminating of the lens or lenses.
- g. A frame that costs more than the Plan allowance.
- h. Cosmetic lenses.
- i. Optional cosmetic processes.
- j. UV (ultraviolet) protected lenses.

2. NOT COVERED

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

- a. Orthoptics or vision training and any associated supplemental testing; plano lenses; or two pair of glasses in lieu of bifocals;
- b. Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available;
- c. Medical or surgical treatment of the eyes;
- d. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.

PROVIDER 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.

I: MONTHLY PREMIUMS:

1.	Employee Only	\$3.69
2.	Employee + Spouse	\$5.85
3.	Employee + Child(ren)	\$5.99
4.	Employee + Family	\$9.24

**Application for Vision Care Benefits**  
 Underwritten by Fidelity Security Life Insurance Company  
 Kansas City, Missouri 64111



**I. GROUP INFORMATION**

Group Name: Clark County, Nevada Tax ID#: 88-6000028  
 DBA Name (If other than above): \_\_\_\_\_  
 Business Physical Address: 500 South Grand Central Pkwy Las Vegas NV 89106  
(Street Address) (City) (State) (Zip)  
 Mailing Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)  
 Day-to-Day Contact Name: Geree Gonzales Title: Manager, Health Benefits  
 Phone Number: ( 702 ) 455-3172 E-Mail Address: Geraldine.Gonzales@ClarkCountyNV.gov  
 Type of Business:  Proprietorship  Corporation  Other (Specify): Government

**PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:**

MEWA  PEO  Trust  Union  VEBA  Casino/Indian Tribe  
 Service Area:  National (U.S.— does not include Puerto Rico)  State Specific\*  
 National (U.S.— does include Puerto Rico)  
 \*If any subsidiary or affiliated companies are to be insured or any Employees/Members are working or residing in a state other than the business address above, please list those states: 10 other governmental agencies

**GROUP DISPLAY NAME (Your Group Name as it should appear to your Employees/Members)**

Company Name: Clark County EPO Vision Plan  
(Maximum of 40 characters, including capitalization, punctuation and spacing.)

**II. GROUP BILLING**

Billing Physical Address: 500 South Grand Central Pkwy Las Vegas NV 89106  
(Street Address) (City) (State) (Zip)  
 Primary Contact Name: Geree Gonzales Title: Manager, Health Benefits  
 Phone Number: ( 702 ) 455-3172 E-Mail Address: Geraldine.Gonzales@ClarkCountyNV.gov  
 Do you have any additional subsidiaries, affiliated companies, or divisions that use another name and will be covered by this plan AND require separate billing invoices?  Yes  No If Yes, please attach and send a separate page signed by you with the following information: Name, Address, Billing Contact Name and Phone Number

**III. PREMIUMS\***

Please indicate the percentage of premium contributed by the Group and the Employee/Member for both the Employee/Member and Dependents; the total for each row must equal 100%.

	Group Contribution	Employee/Member Contribution
Employee/Members:	<u>90 %</u>	<u>10 %</u>
Dependents:	<u>90 %</u>	<u>10 %</u>

Are Employee/Member and Dependent premiums paid through a Section 125 Plan?  Yes  No  
 Are Employee/Member and Dependent premiums collected via payroll deduction?  Yes  No

Premiums shall be payable at the rates included on the attached proposal page.

\*If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.

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**IV. ELIGIBILITY**

Number of Eligible Employees/Members: 20000

Will this plan replace any existing vision coverage?  Yes  No

If "Yes," name of existing insurer: \_\_\_\_\_

Eligible Class(es) of Employees/Members (please check all that apply):

Active employees  Retiree / Leave of Absence   
COBRA-eligible employees  Other: \_\_\_\_\_

**Are the following covered under the plan:**

Domestic Partners:\*  Yes  No

Dependent Children Covered to Age\*: 19 23  26\*\* Other \_\_\_\_\_

Dependent Children who are full-time students covered to age\*: 23 25  26 27 Other \_\_\_\_\_

Dependent Child Age Termination based on:

Day Age is attained  End of Month Age is attained  End of Year Age is attained

*\*Unless state law has different requirements.*

*\*\*Dependent Children covered to age 26 regardless of financial dependency, residency, student status or marital status.*

**MEMBERSHIP INFORMATION**

Who will send enrollment for Active Employees/Members?  Group  Group's TPA

If TPA, TPA Name: HealthSCOPE Benefits

Group/TPA Contact Name: Teresa Crossland

Phone Number: (800 ) 395-7069 E-Mail Address: Teresa.crossland@healthscopebenefits.com

Membership will be an electronic membership file?  Yes  No

Who will send enrollment for COBRA Employees/Members?  Group  Group's TPA

If TPA, TPA Name: HealthSCOPE Benefits

Group/TPA Contact Name: Teresa Crossland

Phone Number: (800 ) 395-7069 E-Mail Address: Teresa.crossland@healthscopebenefits.com

Membership will be an electronic membership file?  Yes  No

**PROBATIONARY PERIOD**

For New Employees/Members: 30 days  60 days 90 days 180 days Other \_\_\_\_\_

Probationary Period is waived for present Employees/Members: Yes  No

Number of Employees/Members who have not yet completed the probationary period: 1000

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**V. PLAN SELECTION**

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

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**VI. EFFECTIVE DATE**

This Policy will become effective at 12:01 a.m. Local Time at the Group's address herein, on

01/01/2022  
MM/DD/YYYY

, provided all the following has been completed prior to this effective date:

- A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).
- B. EyeMed has been furnished a working file of all eligible Employees/Members, in an agreed upon format. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

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The Group hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to pay premiums monthly.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company or EyeMed by mail, email, or telephone.

The Group certifies that all information shown on this application and any attachments is correct and complete as of the date this application is signed. The Group understands that the Company intends to rely on this information in determining if the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**; and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation.

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

Dated at: Las Vegas, Nevada this 21<sup>st</sup> day of July, 2021  
(City) (State) (Day) (Month) (Year)


Signed for the Group: Jessica Colvin Title: Chief Financial Officer

Printed Name: Jessica Colvin

**ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY  
THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID  
LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT**

**WRITING BROKER'S CERTIFYING STATEMENT**

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): Arthur J. Gallagher & Co. Tax ID No.: 36-4291971  
Mailing Address: 6300 South Syracuse Way, Ste. 700 Centennial CO 80111  
(Street Address) (City) (State) (Zip)  
Day-to-Day Contact Name: Shawn Adkins Title: Health & Welfare Consultant  
Day-to-Day Contact Day-to-Day Contact  
Phone Number: (303) 889-2780 E-Mail Address: Shawn\_Adkins@AJG.com  
Commission checks payable to:  Firm  Broker  
Broker Name (print): Shawn Adkins SS#: \_\_\_\_\_  
Broker Phone Number: (303) 889-2780 Broker E-mail Address: Shawn\_Adkins@AJG.com  
Broker Signature: ▶ 

**WRITING GENERAL AGENT'S CERTIFYING STATEMENT**

I certify that I have accurately recorded on this application the information supplied by the applicant, if such information has been provided directly to me for recording purposes, and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): \_\_\_\_\_ Tax ID No.: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)  
Day-to-Day Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Day-to-Day Contact Day-to-Day Contact  
Phone Number: ( ) E-Mail Address: \_\_\_\_\_  
Commission checks payable to:  Firm  General Agent  
General Agent Name (print): \_\_\_\_\_ SS#: \_\_\_\_\_  
General Agent General Agent  
Phone Number: ( ) E-mail Address: \_\_\_\_\_  
General Agent Signature: ▶ \_\_\_\_\_

# Your custom vision quote

## MORE OF WHAT'S BEST, NOT MORE OF THE SAME

Get the most out of your vision plan with these EyeMed highlights:

- Ability to use the frame and contact lens allowances in the same benefit year – worth up to an extra \$60<sup>1</sup>
- Separate contact lens fit & follow-up coverage (leaving the entire allowance for materials)

Plus, with us, you also always get:

THE GROUNDWORK WE LAY FOR YOUR PLAN	BENEFITS THAT REDEFINE EXPECTATIONS	ABOVE ALL ELSE, WE MAKE BENEFITS EASY
<p>America's largest vision network with the right mix of providers<sup>2</sup></p> <p>Several in-network options for buying eyewear online</p>	<p>The freedom to choose any ophthalmic frame, lens or contact lens without restrictions at any of our retail providers, independent provider locations or online.</p> <p>Complimentary HealthyEyes wellness program that keeps the focus on eye health with online tools, articles and videos to make the conversation around vision even easier</p> <p>Members-only savings on eyewear, LASIK, hearing aids and more online options</p>	<p>Cost transparency with our Know Before You Go cost estimator</p> <p>Digital tools like online scheduling<sup>3</sup>, a mobile app and personalized text alerts</p>

We can't wait to work with you –  
Contact Pegah Firozi at [pfirozi@eyemed.com](mailto:pfirozi@eyemed.com) with questions

<sup>1</sup> This document provides highlights of one or more EyeMed plans. Frame allowances may vary by plan. Please consult your EyeMed representative for details.  
Based on the EyeMed Insight network, October 2020.  
At select locations

County of Clark

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
<b>EXAM SERVICES</b>		
Exam	\$10 copay	Up to \$40
<b>FRAME</b>		
Frame	\$0 copay; 20% off balance over \$60 allowance	Up to \$42
<b>CONTACT LENSES</b> <i>(Contact Lens allowance includes materials only)</i>		
Contacts - Conventional	\$0 copay; 15% off balance over \$115 allowance	Up to \$80
Contacts - Disposable	\$0 copay; 100% of balance over \$115 allowance	Up to \$80
Contacts - Medically Necessary	\$0 copay; paid-in-full	Up to \$210
<b>STANDARD PLASTIC LENSES</b>		
Single Vision	\$0 copay	Up to \$30
Bifocal	\$0 copay	Up to \$50
Trifocal	\$0 copay	Up to \$70
Lenticular	\$0 copay	Up to \$70
Progressive - Standard	\$65 copay	Up to \$50
Progressive - Premium	\$65 copay, 20% off retail price less \$120 allowance	Up to \$50

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company  
 Option 1  
 Exam & Materials  
 Select Network  
 Fully Insured  
 Employer Paid  
 Funded Benefits

Frequency

Examination

Once every 12 months

Lenses (in lieu of contacts)

Once every 24 months

Contacts (in lieu of lenses)

Once every 24 months

Frame

Once every 24 months

Rate

Contract Term

48 months

Rate Guarantee

48 months

**MONTHLY RATES**

Subscriber	\$3.69
Subscriber + Spouse	\$5.85
Subscriber + Child(ren)	\$5.99
Subscriber + Family	\$9.24

Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633.

**PLAN DETAILS**

Quote for group situated in the State of NV and will be valid until the 01/01/2022 implementation date. Date Quoted 05/14/2021. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184.

**PLAN EXCLUSIONS/LIMITATIONS**

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If County of Clark has chosen this benefit design, attach this document to the group application and sign here

Jessica Colvin

Signature  
 P201603 TC - 0

Jul 21, 2021

Date

Q-00026279 - QL-0000044768

## County of Clark

# Saving our members some extra green

We're committed to keeping money in our members' pockets.

That's why we offer our members additional discounts above the proposed plan benefits.

### Savings for Members

#### 40% off

additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive

#### 20% off

any item not covered by the plan, including non-prescription sunglasses

#### Lasik

Lasik or PRK from US Laser Network  
15% off retail price or 5% off promotional price

#### Hearing Care

Through Amplifon Hearing Health Care Network, members receive Up to 64% off hearing aids, an extended warranty, free batteries and a low price guarantee

### ADDITIONAL DISCOUNTS

#### VISION CARE SERVICES

#### IN-NETWORK MEMBER COST

##### DISCOUNTED EXAM SERVICES

Retinal Imaging

Up to \$39

##### CONTACT LENS FIT AND FOLLOW-UP

*(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*

Fit and Follow-up - Standard

Up to \$40

Fit and Follow-up - Premium

10% off retail price

##### DISCOUNTED LENS OPTIONS

Anti Reflective Coating - Standard

\$45

Photochromic - Non-Glass

20% off retail price

Polycarbonate - Standard

\$40

Scratch Coating - Standard Plastic

\$15

Tint - Solid or Gradient

\$15

UV Treatment

\$15

##### OTHER ADD-ON SERVICES AND MATERIALS

20% off retail price

#### DISCOUNT DETAILS

Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.