

# **CITY OF COLORADO SPRINGS**

## **VISION BENEFITS PLAN**

### **2012 PLAN DOCUMENT**

**Effective Date: January 1, 2012**

**This document is intended as an outline of coverage available and is not intended to be a legal contract. If a discrepancy exists between this document and the various summary plans, contracts and agreements, the provision of the actual service agreements and/or contracts will prevail.**

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## INTRODUCTION

### WHAT THIS DOCUMENT TELLS YOU

- A. This document describes the Vision Benefits Plan for Employees and eligible covered Dependents of the City of Colorado Springs, herein referred to as the Employer or Plan Administrator. The Vision Benefits Plan, herein referred to as the Plan, described in this document is effective as of **January 1, 2012**. If you have declined/waived vision coverage, the following chapters do not apply to you.
- B. This document will help you understand the Plan at the City of Colorado Springs, and it will also help you use them well. You should review this document in its entirety and share it with those eligible members of your family who are or will be covered by the Plan. This document will give you an understanding of:
- the benefit coverage provided;
  - the procedures to follow in submitting claims; and
  - your responsibilities to provide necessary information to the Plan.

- C. Vision Service Plan (VSP) of Colorado, herein referred to as VSP, is the claims administrator of the Plan. To obtain vision care for yourself and/or your eligible dependents, you may at any time choose to see:
- A VSP Network Doctor and receive the VSP Network Doctor Benefits; or
  - Any optometrist, optician or ophthalmologist and receive Out-Of-Network Benefits.
  - Note that the services covered are the same for either choice. You have a lower out-of-pocket cost advantage if you select a VSP Network Doctor.

You may obtain a list of VSP Network Doctors from VSP's Web site at [www.vsp.com](http://www.vsp.com), or it may be viewed online on your Employer's intranet/Internet site. If you need a hard copy of the directory, you may request it from your Employer or by calling VSP's Member Services at 800-877-7195.

- D. **Some eye care benefits are available under the Medical Benefits Plan if you do not elect coverage under this Plan.** For example, the EPO Mid-Level Medical Plan provides for *medically necessary* eye care treatment, as well as annual routine eye exams; however, these Plans do not provide eyeglasses, etc. Please refer to the Medical Benefits Plan about vision benefits.

If enrolled in the Vision Service Plan, you may **not** submit claims to the Medical Plan for routine eye exams. Routine eye exam claims submitted to the Medical Plan will be **denied** if you are enrolled in the VSP Plan.

## **HOW TO USE THE PLAN – WHEN USING VSP NETWORK DOCTORS**

1. When you make an appointment with a VSP Network Doctor, let them know you have coverage through VSP and provide them with your member ID number (last four digits of subscriber social security number) and date of birth.
2. The VSP Network Doctor's office will verify your benefits and eligibility directly with VSP. Verification of eligibility is valid for thirty (30) days. You can verify eligibility by calling VSP's Member Services at 800-877-7195 or visit VSP's Web site at [www.vsp.com](http://www.vsp.com).
3. The VSP Network Doctor will file your claim directly with VSP and collect any co-pays or overages not covered under the plan at the time of your visit.
4. For additional information on how to utilize your vision benefits, contact VSP at [www.vsp.com](http://www.vsp.com) or call VSP's Member Services at 800-877-7195.

## **HOW TO USE THE PLAN – WHEN USING OUT-OF-NETWORK PROVIDERS**

You have the option of seeing an Out-Of-Network provider. You will be required to pay the provider in full at the time of service. When you use an Out-Of-Network provider, you must file a claim with VSP. There is no assurance that the Schedule Of Benefits will be sufficient to pay for the exam or the glasses/contacts. To ensure a timely reimbursement, you can download the claim form directly from your Employer's intranet/Internet site; or log on to VSP's Web site and access the claim form. Simply follow the below instructions:

- Sign on to [www.vsp.com](http://www.vsp.com)
- Select "Detailed Coverage" (or "More About My Benefits")
- Click "Find out the Facts" for Out-Of-Network Coverage at the bottom of the page
- Click the link for "How to Request Reimbursement"
- Follow the instructions

If you do not have intranet/Internet access, send the following to VSP:

- An itemized receipt listing the services received.
- The name, address and phone number of the Out-Of-Network provider.
- The covered member's ID number, name, address and phone number.
- The name of the organization that offers your VSP coverage.
- The patient's name, date of birth, address and phone number.
- The patient's relationship to the covered member, such as "self," "spouse," "child".

Keep a copy of the claim information and send the originals to: VSP, P.O. Box 997105, Sacramento, CA 95899-7105.

Request for claim payments for Out-Of-Network providers must be submitted within **180 days** from the date the expense was incurred.

## SCHEDULE OF BENEFITS

Vision benefits for you and your eligible dependents:

	<b>VSP Network Doctor Co-pay (Patient Pays)</b>	<b>Out-Of-Network Provider Reimbursement Schedule (Up to Maximum Benefit Plan Will Pay)</b>
<b>Eye Exam</b>	<b>\$10</b> co-pay	\$30
<b>Lenses (each)</b> • <b>Single</b> • <b>Bi-focal</b> • <b>Tri-focal</b> • <b>Lenticular</b>	<b>\$10</b> co-pay for lens materials <sup>(1)</sup> Covered in full Covered in full Covered in full Covered in full	Up to \$40 <sup>(2)</sup> Up to \$55 <sup>(2)</sup> Up to \$55 <sup>(2)</sup> Up to \$105 <sup>(2)</sup>
<b>Frame (Lens excluded)</b>	\$15 co-pay 1 pair per <b>Plan Year</b> (Based on time elapsed since last benefit) <b>\$150</b> retail allowance <sup>(3)</sup>	\$30
<b>Contacts</b> (chosen instead of glasses)	\$150 <sup>(4)</sup> allowance	Up to \$130 <sup>(4)</sup> allowance

**NOTES:**

- (1) The VSP Network Doctor co-pay for lenses is **\$10** for either one (1) lens or two (2) lenses. Lens options are available to you at VSP's member preferred pricing. **All dependent children will be covered for polycarbonate lenses, which was added by VSP in a commitment to supporting children's eyecare needs.**
- (2) The Out-Of-Network Benefit allowance for lenses is for two (2) lenses.
- (3) In the event you select a frame that exceeds the allowance, you will receive an additional 20% discount off any amount over of the allowance from a VSP Network Doctor.
- (4) Contacts benefit is in lieu of glasses only, i.e., does not include the cost of the eye exam. The allowance applies to the cost of your contacts, the fitting, and the evaluation exam. This exam is in addition to your eye exam to ensure proper fit of contacts.
- (5) Laser vision correction services are available with many of the nation's finest laser surgery facilities and doctors. VSP's contracted laser centers offering you a discount off PRK, LASIK and custom LASIK surgeries. Visit VSP's Web site at [www.vsp.com](http://www.vsp.com) for more information.
- (6) VSP Doctors provide a 15% discount of their professional fees for the contact lens fitting and evaluation exam.

**Low Vision Benefit:**

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

	<b>VSP Network Doctor Co-pay (Patient Pays)</b>	<b>Out-Of-Network Provider<sup>(3)</sup> Reimbursement Schedule (Up to Maximum Benefit Plan Will Pay)</b>
<b>Supplementary Testing <sup>(1)</sup></b>	Covered in full	Up to \$125
<b>Supplemental Care Aids <sup>(2)</sup></b>	25% co-pay	75% of cost
<b>Benefit Maximum</b>	<b>The maximum benefit available is \$1,000 (excluding Co-pays) every 2 years.</b>	

**NOTES:**

- (1) Complete low vision analysis and diagnosis which includes a comprehensive exam of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- (2) Subsequent low vision aids as Visually Necessary or Appropriate.
- (3) Out-Of-Network Provider – Low Vision benefits secured from an Out-Of-Network Provider are subject to the same time limits and co-pay arrangements as described above for a VSP Network Doctor. The Covered Member should pay the Out-Of-Network Provider their full fee. The Covered Member will be reimbursed in accordance with an amount not to exceed what VSP would pay a VSP Network Doctor in similar circumstances. Note: there is no assurance that this amount will be within the 25% co-pay feature.

**HOW OFTEN SERVICES ARE AVAILABLE**

**Eye Exam:** One exam for each covered member **per Plan Year.**

**Prescription Eyewear:**

- Lenses: One pair of lenses for each covered member **per Plan Year.**
- Frames: One set of frames for each covered member **per Plan Year.**
- Contacts: One set of contacts for each covered member **per Plan Year.**

**NOTE:** You are not eligible for glasses and contacts in the same Benefit Period.

## DEFINITIONS

### **Co-pay**

The set dollar amount (as defined in the Schedule of Benefits) you are responsible for paying when you incur an eligible expense for certain services.

### **Doctor**

Any licensed optometrist or ophthalmologist practicing within the scope of his/her profession.

### **Ophthalmologist**

A medical doctor who specializes in eye care.

### **Optician**

A person who is legally qualified to supply eyeglasses according to prescription written by an ophthalmologist or optometrist.

### **Optometrist**

A “doctor of optometry,” trained and legally qualified to perform eye exams and to prescribe lenses.

### **VSP Network Doctor**

A network of doctors who have been selected for their demonstrated ability to practice exceptional eye care on a cost-effective basis. You have complete flexibility within the Plan to obtain benefits from either a VSP Network Doctor or an Out-Of-Network provider at any time.

### **Provider of Services**

An ophthalmologist, optometrist or optician who provides one or more vision care services covered under this Plan.

## EXPLANATION OF COVERED CHARGES

### **Eye Exam**

A comprehensive exam of the eyes to determine the presence of vision problems or other abnormalities.

### **Lenses**

The Plan will provide benefits for basic glass, plastic or other transplant material lenses commonly held in place by frames away from the eyes.

**All dependent children will be covered for polycarbonate lenses, which was added by VSP in a commitment to supporting children’s eyecare needs.**

**Contacts**

You may *choose* contacts instead of glasses and the benefit is paid according to the Schedule Of Benefits.

**Frame**

The benefit will cover the majority of frames manufactured. It does not provide for fashion or designer frames or a large frame that requires oversized lenses.

**LIMITATIONS--VSP NETWORK DOCTOR BENEFITS**

This Plan is designed to cover visual needs rather than cosmetic materials. When you select any one of the following extras, the Plan will pay the basic cost allowed, and you will pay any additional cost for: (a) a frame that costs more than the Plan limit; (b) oversize lenses; (c) blended lenses; (d) coated lenses; (e) tinted lenses; (f) photochromatic lenses; (g) two pair of glasses in lieu of lined bifocals.

**WHAT IS NOT COVERED**

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

1. Orthoptics or vision training, plano (non-prescription) lenses, or glasses secured when there is no prescription change.
2. Lenses and frames furnished under this Plan which are lost or broken. They will not be replaced except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Corrective vision treatment of an Experimental Nature.
5. Costs for services and/or eyewear above Plan benefit allowances.
6. Services and/or eyewear not indicated on this Schedule as covered Plan Benefits.
7. Services or eyewear provided as a result of any Workers' Compensation Law, or similar legislation or those obtained through or required by any government agency or program whether Federal, State, or any subdivision thereof.
8. Any eye exam by an employer as a condition of employment; or any service or eyewear provided by any other vision care plan, or group benefit plan containing benefits for vision care.

## **VISION INSURANCE WAIVER**

As an active employee, you may waive vision coverage without benefit restriction. However, if you want to re-enroll at a later date, you may be subject to limitations as defined by the most current Plan contract. Also see Retiree Eligibility Rules below.

## **ELIGIBILITY AND RIGHTS TO CONTINUATION COVERAGE**

You and your eligible dependents will be subject to meeting eligibility rules/provisions, rules of Open Enrollment, or the allowable plan change rules under the Cafeteria Plan or Medical Benefits Plan. Rules and provisions for the Vision Plan are the same as those explained by the Medical Benefits Plan, except as those rules specified below for Retirees. Eligibility definitions, rights to continuation, termination provisions and requirements of the Vision Plan are the same as those described by the Medical Benefits Plan. Please refer to the Medical Benefits Plan for information on eligibility, rights to continuation, the Plan's rights to seek recovery and election change rules.

### **Retiree Eligibility Rules:**

1. At the time of retirement, an employee may elect to either:
  - a. continue their existing vision coverage at the time of their retirement as long as the employer offers this benefit to retirees and payment is received; **or**
  - b. may elect to waive this coverage at the time of their retirement.
2. An employee is not entitled to add vision coverage at the time of retirement if they previously opted/waived out of the Vision Insurance Plan.
3. A retiree may not increase their coverage tier. For example, a retiree with retiree only coverage, may not increase their coverage tier to retiree and spouse coverage.
4. Once a retiree waives their Vision coverage, they are no longer eligible for the Plan and may not re-enroll at a later date.

## **COORDINATION OF BENEFITS (COB)**

Due to the Plan's limited annual benefit provision, VSP does not coordinate benefits with other insurance carriers.

## APPEAL PROCESS

You have the right to appeal if:

- You do not agree with VSP's decision about your health care.
- VSP will not approve or give you care you feel it should cover.
- VSP is stopping care you feel you still need.

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

In some cases, you have a right to a faster, 72-hour appeal. You can get a fast appeal if your health or ability to function could be seriously harmed by waiting 30 days for a standard appeal. If you ask for a fast appeal, VSP will decide if you get a 72-hour/fast appeal. If not, your appeal will be processed in 30 days. If any doctor asks VSP to give you a fast appeal, or supports your request for a fast appeal, it must be given to you.

**If you want to file an appeal, which will be processed within 30 days, do the following:**

File the request in writing with VSP at the following address:

VSP  
Attn: Prior Authorization Department  
3333 Quality Drive,  
Rancho Cordova, CA 95670

Even though you may file your requests with VSP, VSP may transfer your request to the appropriate agency for processing. Your appeal request will be processed within 30 days from the date your request is received.

**If you want to file a fast appeal, which will be processed within 72 hours, do the following:**

- File an oral or written request for a 72-hour appeal. Specifically state that "I am requesting an: expedited appeal, fast appeal or 72-hour appeal." Or "I believe that my health could be seriously harmed by waiting 30 days for a normal appeal."
- To file a request orally, call 800-877-7195. VSP will document the oral request in writing.

**Help with your appeal:** If you decide to appeal and want help with your appeal, you may have your doctor, a friend, lawyer, or someone else help you. There are several groups that can help you. If you are covered by Medicare, you may contact the Medicare Rights Center toll free at 888-HMO-9050. You may also contact the National Aging Information Center at 202-619-7501 to request the phone number of your local

## **PRIVACY, CONFIDENTIALITY, RELEASE OF RECORDS OR INFORMATION**

The Plan complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and to the Standards of Privacy of Individually Identifiable Health Information, which is effective April 14, 2003, hereafter referred to as “HIPAA Privacy Regulations”. The purpose of the regulations is to secure individually identifiable Protected Health Information, hereafter referred to as “PHI”.

**Protected Health Information (PHI)** means any information that is created or received by the Plan, which identifies an individual and relates to the past, present, or future physical or mental health or condition of that individual.

**Eligibility Information** means information, whether written or oral, which describes a participant or a participant’s eligibility for past or future health care and the extent to which those services are covered under the participant’s Plan. Eligibility information **does not** include Protected Health Information.

1. **Permitted uses and disclosures of PHI:** The HIPAA Privacy Regulations allows or requires that PHI be used or disclosed only:
  - for purposes of “treatment, payment or health care operations” (TPO), **or**
  - for certain public health and safety purposes (such as reporting abuse or communicable diseases), where required by law or as part of a legal or regulatory proceeding, or for law enforcement, **or**
  - directly to the individual to whom the PHI pertains, **or**
  - pursuant to a valid signed Authorization by the individual to whom the PHI pertains.
2. **Disclosure Permitted only Pursuant to Certification:** Plan Administrator will disclose PHI only for purposes of plan administration (such as payment or health care operations) and agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the Employer and Plan Administrator.
3. **Plan Administrator’s Use or Disclosure of PHI:** Plan Administrator will not use PHI for any purpose not required by law or allowed by the Plan. Specifically, Plan Administrator will not use or disclose PHI obtained from the Plan for decisions relating to employment or in connection with other plans (e.g., disability plans, workers’ compensation plans), unless pursuant to a valid Authorization.

When using or disclosing PHI or when requesting PHI from another party, the Plan Administrator must make reasonable efforts to limit PHI to the **minimum necessary** to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the **minimum necessary** to satisfy the purpose of the request.

4. **Classes of Employees With Access to PHI:** The following employees (or classes of employees) of, or other persons under the control of, Plan Administrator will have access to the **minimum necessary** PHI solely for the purposes specified below, and only for plan administration functions performed on behalf of the Plan. The type of information that individual classes of employees may or may not be defined under HIPAA as PHI; and, therefore just because it is listed, it does not mean that the information handled is in fact PHI. Other employees of Plan Administrator shall **not** have access to PHI.
- **Plan Administrator’s Benefits Section and Human Resources Service Center (Utilities only):** Employees who work in the Benefits Section will have access to PHI to the extent necessary to assist employees and their family members if they request such assistance in getting benefits claims resolved.
  - **Plan Administrator’s Information Technology Employees:** Employees who work in Human Resources and/or Information Technology who have access to Human Resources technology, including software, computers, servers, etc., will have access to PHI to the extent necessary for the sole purpose of programming and/or repairing of such systems.
  - **Plan Administrator’s Benefit Section:** Employees who work in the Benefits Section will have access to PHI:
    1. To the extent necessary to work with the Plan Administrator’s Subrogation Entity to help the Plan obtain reimbursement when appropriate;
    2. For activities related to securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance);
    3. For activities related to the creation, renewal or replacement of a contract for health insurance or health benefits services (i.e., utilization review, pharmacy benefit management, large claim auditor, third party claim administrator, network access, etc);
    4. To the extent necessary to correspond with other group health plans on coordination of benefits issues;
    5. For the activities associated with the Claim Appeal Process, as a member of the Grievance Committee will have access to PHI to the extent necessary to fulfill the Committee’s responsibility to review and determine appeals from denied claims under this Plan.
  - **Plan Administrator’s Legal Department:** Employees who work in the Legal Department will have access to PHI to the extent necessary to respond to, defend against, and provide necessary information to outside counsel for responding and defending against, lawsuits against the Plan, or other lawsuits that also require benefits information or PHI; or to the extent necessary to enforce subrogation provisions in the Plan.

- **Plan Administrator's Finance Department:** Employees who work in the Finance Department will have access to PHI to the extent necessary for the financial transactions related to the Employee Benefits Trust Fund.
6. **Sanctions on Employees who Fail to Comply:** If any of the employees or individuals under the Plan Administrator's control (listed above) fails to comply with these provisions regarding use or disclosure of PHI, the Plan Administrator shall impose reasonable corrective actions on such individual(s) to end such non-compliance.
  7. **Sanctions on Benefit Vendors who Fail to Comply:** If any of the benefit vendors, also known as business associates, under the Plan fails to comply with the HIPAA Privacy Regulations regarding the use or disclosure of PHI, the Plan Administrator will take corrective action on such benefit vendor(s) to end such non-compliance.
  8. **Plan Administrator to Document and Rectify Misuse of PHI:** Plan Administrator will document and attempt to rectify, if possible, any misuses or impermissible disclosures of PHI of which it becomes aware.
  9. **Access to and Amendment of PHI.** Plan participants will be given appropriate access to their PHI, and the Plan will amend or correct PHI if requested to do so by the individual, where appropriate under the HIPAA Privacy Regulations.
  10. **Accounting for Disclosures.** Plan Administrator will track disclosures of PHI, as required by the HIPAA Privacy Regulations (during the prior six years, but not prior to April 14, 2003), and will provide (to the plan participants who so request) an accounting of disclosures to third parties that were made other than for treatment, payment or health care operations or pursuant to a valid authorization signed by the individual, or to the individual him/herself, as well as disclosures for certain public health and safety purposes (such as reporting abuse or communicable diseases), where required by law or as part of a legal or regulatory proceeding, or for law enforcement.
  11. **Grievance Procedure:** The following procedures apply for resolving issues of alleged noncompliance with HIPAA Privacy Regulations:
    - Any Plan participant who feels the Plan has unlawfully used or disclosed his/her PHI may file a written complaint with the Plan's Privacy Officer; and,
    - Any Plan participant may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 2000 Independence Avenue SW., Washington, DC 20201.
  12. **Return or Destruction of PHI:** Plan Administrator will return or destroy, **to the extent feasible**, all PHI received from the Plan when such information is no longer needed for the purpose for which it was received. If return or destruction is not feasible, Plan Administrator will limit its uses and disclosures to those purposes that make the return or destruction infeasible.

13. **Cooperation with Health and Human Services (HHS) Request:** Plan Administrator will make its internal practices, books and records regarding use and disclosure of PHI received from the Plan available to HHS, to the extent required for HHS to audit to monitor compliance.
14. **Disclosure of Certain Enrollment Information to the Plan Administrator:** Pursuant to HIPAA Privacy Regulations, the Plan may disclose about whether an individual is enrolled in the Plan or is enrolled in or disenrolled from a health insurance issuer for the purposes of coordination of benefits. Eligibility information **does not** include Protected Health Information.
15. **Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage.** The Plan Administrator can disclose PHI to current and potential stop-loss carriers, excess loss carriers for underwriting and other purposes to obtain and maintain stop-loss coverage related to benefit claims under the Plan. Such disclosures shall be made in compliance with the HIPAA Privacy Regulations.

Detailed policies and procedures with respect to the HIPAA Privacy Regulations are posted on the respective Employer's intranet/Internet Web sites or you may contact Human Resources directly for further information regarding these regulations.

## **OTHER PLAN INFORMATION**

### **NAME OF THE PLAN**

City of Colorado Springs Vision Benefit Plan

### **NAME AND ADDRESS OF EMPLOYER MAINTAINING THE PLAN**

The City of Colorado Springs, the Plan Administrator  
30 S. Nevada, Suite 602  
Colorado Springs, CO 80903  
719-385-5904

### **NAME AND ADDRESS OF PRIVACY OFFICER**

Human Resources Director  
30 South Nevada Avenue  
Colorado Springs, CO 80903  
719-385-5904

### **CLAIMS ADMINISTRATOR**

Vision Service Plan (VSP) of Colorado  
1050 17<sup>th</sup> Street, Suite 1885  
Denver, CO 80265  
800-877-7195

## **PLAN YEAR**

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

## **PLAN AMENDMENTS OR TERMINATION OF PLAN**

The Employer reserves the right to amend or terminate this Plan, or any part of it at any time. Amendments may be made in writing by the City's designated officers and become effective upon the written approval of the City's Human Resources Director, or on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated, and/or new coverages may be added.

## **DISCRETIONARY AUTHORITY OF CLAIMS ADMINISTRATOR AND DESIGNEES**

In carrying out their respective responsibilities under the Plan, the Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

## **NO LIABILITY FOR PRACTICE OF MEDICINE**

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Claims Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.