SECOND AMENDMENT TO CHAUTAUQUA COUNTY SCHOOL DISTRICTS' MEDICAL HEALTH PLAN

Effective October 1, 2014

The Chautauqua County School Districts' Medical Health Plan Summary Plan Description (SPD) is amended as follows:

1. The **Summary of Benefits** for the Indemnity Medical Plan, Point of Service Plan and Preferred Provider Organization Plan are deleted and replaced by the **Summary of Benefits and Coverage** in **Exhibit A** attached.

2. Section II, **Key Terms**, definition of Dependent is modified by deleting the second, third and fourth bullets and substituting the following:

- Children under age 26 regardless of marital status, student status, residency or financial dependence.

- Unmarried children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the Mental Hygiene Law, or physical handicap and who became so incapable prior to the attainment of the age at which dependent coverage would otherwise terminate and who are chiefly dependent upon such member for support and maintenance. The Plan may ask you for proof of the handicap (if proof of the handicap is not produced within 31 days of request, participation in the Plan will end).

- For the Dental and Vision Plans only, unmarried children age 19 or older until reaching 25 years of age, provided the child is a full-time student in an educational institution or is dependent on you for support and maintenance.*

  * Financial dependency is generally proved by being able to claim a dependent on your federal tax return or by contributing more than 50% of the cost for your child's support and maintenance.

3. Section III A. 1. **Employee Eligibility**, second paragraph is deleted and replaced as follows:

In addition to your biological children, any stepchildren, foster children, legally adopted children, or children placed with you for adoption or under legal guardianship may also be covered if they meet the above requirements.

4. Section III. A. 1. **Employee Eligibility**, third paragraph is deleted and replaced as follows:

- Under Federal Law, coverage for adult children, regardless of marital status, is available up to age twenty-six (26). The parent of the adult child will need to be enrolled in the appropriate tier of coverage prior to or at the date of enrollment of the adult child. Effective January 1, 2014, children up to age 26 may participate in the Plan even if they have another offer of coverage through an employer.

5. Section III. B. 4. **Adding or Dropping Family Member Coverage** is modified in the second paragraph as follows:

With the exception of newborns, new dependents acquired through "life events" (marriage, , adoption, foster care or legal guardianship) must be enrolled through the submission of an enrollment form within 30 days of the event or must wait until the next open enrollment to become covered dependents. A newborn or adopted newborn must be enrolled through the submission of an enrollment form within 30 days from the notice of birth, or the date on which the plan receives notice.

6. Section III. D. 1. **Major Medical Benefits-Key Features (Indemnity)** is modified to substitute the following at the end of the Preventive Services section:

> Note that cost sharing (deductibles and coinsurance) may apply if a preventive service is provided during an office visit when the preventive service is not the primary purpose of the visit. A complete list of the covered preventive services is available at http://www.uspreventiveservicestaskforce.org/recommendations.htm or will be mailed to you upon request by contacting Chautauqua County School Districts' Medical Health Plan, 7 W. Third Street, Jamestown, New York 14701 Attn: Benefits Consultant.

7. Section III. D. 2. a. **Inpatient Hospital Care (Indemnity)** is modified to add the following at the end of the section:

- End of Life Care. If you are diagnosed with advanced cancer and you have fewer than 60 days to live, the Plan will cover acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients. Your attending physician and the facility's medical director must agree that your care will be appropriately provided at the facility. If the Plan disagrees with your admission to the facility, the Plan will have the right to initiate an expedited appeal to an external appeal agent. The Plan will cover and reimburse the facility for your care, subject to any applicable limitations in this Summary Plan Description until the external appeal agent renders a decision in the Plan's favor.

  The Plan will reimburse Non-Participating Providers for this end of life care as follows:

  - The Plan will reimburse a rate that has been negotiated between the Plan and the Provider.

- If there is no negotiated rate, the Plan will reimburse acute care at the facility's current Medicare acute care service rates, or

- If it is an alternate level of care, the Plan will reimburse at 75% of the appropriate Medicare rates.

- Limitations/Terms of Coverage. When you are receiving inpatient care in a hospital or other facility as described above, the Plan will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies you take home from the facility. The Plan does not cover radio, telephone and television expenses, or beauty or barber services.

8. Section III. D. 3. f (12) **Routine Mammogram and Pap Smear (Indemnity)** is modified to add a new third bullet as follows:

- Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to deductibles and coinsurance.

9. Section III. D. 3. f (13) **Well-Child Care (Indemnity)** is modified to add the following:

The Plan covers well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan also covers preventive care and screenings as provided for in the comprehensive guidelines supported by Health Resources and Services Administration and items or services with an "A" or "B" rating from the United States Preventive Services Task Force. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, we will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also covered. This benefit is provided to members from birth through attainment of age 19 and is not subject to copayments, deductibles or coinsurance.

10. Section III. D. 3. f (14) **Other Medical Services (Indemnity)** is modified to add the following:

The Plan pays 100% of covered charges for the following health care services for women when the services have a rating of A or B in the current recommendations of the United States Preventive Services Task Force, are recommended by the Advisory Council on Immunization Practices, or are included in Health Resources and Services Administration Guidelines:

- Screening for Gestational Diabetes

- Hepatitis B screening (pregnant women only)
- HIV screening and counseling
- Human Papillomavirus (HPV) testing
- FDA approved contraceptive methods and counseling (refer to the Plan's Contraceptive Drugs and Devices Rider)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies, and counseling
- Routine adult physicals related to a preventive visit are covered once every calendar year regardless of whether 365 days have elapsed.

11. Section III. D. 3. f **Additional Benefits – Traditional/Indemnity Plan** is modified to add the following at the end of the section:

(19) Diagnosis and Treatment of Autism Spectrum Disorder.

We cover the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- Screening and Diagnosis. We cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- Assistive Communication Devices. We cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist if you are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

Repair, replacement fitting and adjustments of such devices are covered when made necessary by normal wear and tear or significant change in your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered. Coverage will be provided for the device most

appropriate to your current functional level. We will not provide coverage for delivery or service charges or for routine maintenance.

- Behavioral Health Treatment. We cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We cover applied behavior analysis when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

Effective January 1, 2014, our coverage of applied behavior analysis services is limited to 680 hours per covered member per Plan year.

- Psychiatric and Psychological Care. We cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.

- Therapeutic Care. We cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise covered under this Plan.

- Pharmacy Care. We cover prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Plan.

Limitations. We will not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Plan for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed physician or licensed psychologist.

You are responsible for any applicable deductible, copayment, or coinsurance provisions under this Plan for similar services. For example, any deductible, copayment, or coinsurance that applies to physical therapy visits generally will also apply to physical therapy services covered under this benefit; and any deductible, copayment, or coinsurance for prescription drugs generally will also apply to prescription drugs covered under this benefit. Any deductible, copayment, or coinsurance that applies to office visits will apply to assistive communication devices covered under this paragraph.

Nothing in this Plan shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

(20) Chemotherapy.

Chemotherapy is covered in an outpatient facility or a health care professional's office. Orally-administered anti-cancer drugs are covered under the Prescription Drug section of this SPD.

12. Section III. D. 4. **Pregnancy and Maternity (Indemnity)** is modified to add the following at the end of the section:

In addition, maternity care coverage includes comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and includes costs for renting breastfeeding equipment.

13. Section III.D.5. **Participation in Clinical Trials (Indemnity)** is added to read as follows:

a. Definitions. As used in this Section III.D.5, the following terms shall have the meanings set forth below:

(i) *Approved Clinical Trial.* A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following paragraphs:

Federally Funded Trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- The National Institutes of Health;
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;

- Cooperative group or center of any of the entities above or the Department of Defense or the Department of Veterans Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- Any of the following if the conditions described in paragraph (2) are met: The Department of Veterans Affairs, The Department of Defense or The Department of Energy.

The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(ii) *Life-threatening Condition.* Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) *Qualified Individual.* An individual who is a participant or beneficiary in the Plan who has coverage under the Plan and who meets the following conditions:

- The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

- Either:

  - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in the paragraph above; or

  - the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in the paragraph above.

(iv) *Routine Patient Costs.* All items and services consistent with coverage provided under the Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. The term "Routine Patient Costs" does not include the cost of: 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or 3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

b. Coverage. Effective July 1, 2014, for Qualified Individuals provided coverage under the Plan, the Plan:

(i) May not deny the individual participation in an Approved Clinical Trial, as defined in subsection a.(i) above;

(ii) Subject to subsection (c), may not deny, limit or impose additional conditions on, the coverage of Routine Patient Costs for items and services furnished in connection with participation in the trial; and

(iii) May not discriminate against the individual on the basis of the individual's participation in such trial.

14. Section III.E.1. **Description of Point of Service Benefit** is modified to substitute a new third paragraph as follows:

The out-of-network benefit level will be paid for all claims submitted by any out-of-network providers regardless of where you live or your ability to access in-network providers. If you receive services from providers located outside the counties of Erie, Niagara, Orleans, Genesee, Cattaraugus, Chautauqua, Wyoming, and Allegany in the State of New York or providers located in other states such as Pennsylvania, claims will not be paid at in-network rates because the Plan has no provider network in those areas.

15. Section III.E.1. **Description of Point of Service Benefit** is modified to add the following at the end of the Preventive Services section:

> Note that cost sharing (copays, deductibles and coinsurance) may apply if a preventive service is provided during an office visit when the preventive service is not the primary purpose of the visit. A complete list of the covered preventive services is available at http://www.uspreventiveservicestaskforce.org/recommendations.htm or will be mailed to you upon request by contacting Chautauqua County School Districts' Medical Health Plan, 7 W. Third Street, Jamestown, New York 14701 Attn: Benefits Consultant.

16. Section III. E. 3. b. **Inpatient Hospital Care (POS)** is modified to add the following at the end of the section:

- End of Life Care. If you are diagnosed with advanced cancer and you have fewer than 60 days to live, the Plan will cover acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients. Your attending physician and the facility's medical director must agree that your care will be appropriately provided at the facility. If the Plan disagrees with your admission to the facility, the Plan will have the right to initiate an expedited appeal to an external appeal agent. The Plan will cover and reimburse the facility for your care, subject to any applicable limitations in this Summary Plan Description until the external appeal agent renders a decision in the Plan's favor.

The Plan will reimburse Non-Participating Providers for this end of life care as follows:

- The Plan will reimburse a rate that has been negotiated between the Plan and the Provider.

- If there is no negotiated rate, the Plan will reimburse acute care at the facility's current Medicare acute care service rates, or

- If it is an alternate level of care, the Plan will reimburse at 75% of the appropriate Medicare rates.

- Limitations/Terms of Coverage. When you are receiving inpatient care in a hospital or other facility as described above, the Plan will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies you take home from the facility. The Plan does not cover radio, telephone and television expenses, or beauty or barber services.

17. Section III. E. 3. k **Physicals (POS)** is modified as follows:

In-network, after a $10 copayment, the Plan pays 100% of covered charges, without a deductible, for comprehensive adult routine physicals that are not conducted during a well care visit. You will be responsible for the entire cost if the physical is provided by an out of network provider.

Adult physical exams conducted during well care visits by an in-network provider in accordance with the Health Resources and Services Administration guidelines or United States Preventative Services Task Force guidelines are not subject to a copay, coinsurance or deductible.

A comprehensive adult routine physical or adult well care visit is covered once every calendar year, regardless of whether 365 days have elapsed.

18. Section III. E .3. s. **Well-Child Care (POS)** is modified to add the following:

> The Plan covers well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan covers preventive care and screenings as provided for in the comprehensive guidelines supported by Health Resources and Services Administration and items or services with an "A" or "B" rating from the United States Preventive Services Task Force. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, we will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also covered. This benefit is provided to members from birth through attainment

of age 19 and is not subject to copayments, deductibles or coinsurance when provided by a Participating Provider.

19. Section III. E.3. t. (6) **Additional Benefits (POS)** is modified to add a new third bullet as follows:

- Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to deductibles and coinsurance.

20. Section III. E. 3. t. (11) **Other Services (POS)** is modified to add the following:

The Plan pays 100% of covered charges for the following health care services for women when provided in network and when the services have a rating of A or B in the current recommendations of the United States Preventive Services Task Force, are recommended by the Advisory Council on Immunization Practices, or are included in Health Resources and Services Administration Guidelines:

- Screening for Gestational Diabetes
- Hepatitis B screening (pregnant women only)
- HIV screening and counseling
- Human Papillomavirus (HPV) testing
- FDA approved contraceptive methods and counseling (refer to the Plan's Contraceptive Drugs and Devices Rider)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies, and counseling

21. Section III. E. 3. t. **Additional Benefits (POS)** is modified to add the following at the end of the section:

(12) Diagnosis and Treatment of Autism Spectrum Disorder.

We cover the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- Screening and Diagnosis. We cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- Assistive Communication Devices. We cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist if you are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

  Repair, replacement fitting and adjustments of such devices are covered when made necessary by normal wear and tear or significant change in your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered. Coverage will be provided for the device most appropriate to your current functional level. We will not provide coverage for delivery or service charges or for routine maintenance.

- Behavioral Health Treatment. We cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We cover applied behavior analysis when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

  Effective January 1, 2014 our coverage of applied behavior analysis services is limited to 680 hours per covered member per Plan year.

- Psychiatric and Psychological Care. We cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.

- Therapeutic Care. We cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such

services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise covered under this Plan.

- Pharmacy Care. We cover prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Plan.

  Limitations. We will not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Plan for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed physician or licensed psychologist.

  You are responsible for any applicable deductible, copayment, or coinsurance provisions under this Plan for similar services. For example, any deductible, copayment, or coinsurance that applies to physical therapy visits generally will also apply to physical therapy services covered under this benefit; and any deductible, copayment, or coinsurance for prescription drugs generally will also apply to prescription drugs covered under this benefit. Any deductible, copayment, or coinsurance that applies to office visits will apply to assistive communication devices covered under this paragraph.

  Nothing in this Plan shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

(13) Chemotherapy.

Chemotherapy is covered in an outpatient facility or a health care professional's office. Orally-administered anti-cancer drugs are covered under the Prescription Drug section of this SPD.

22. Section III. E. 4. **Pregnancy and Maternity (POS)** is modified to add the following at the end of the section:

> In addition, maternity care coverage includes comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and includes costs for renting breastfeeding equipment.

23. Section III.E.5 **Participation in Clinical Trials (POS)** is added to read as follows:

a. Definitions. As used in this Section III.E.5, the following terms shall have the meanings set forth below:

(i) *Approved Clinical Trial.* A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following paragraphs:

- Federally Funded Trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - The National Institutes of Health;
    - The Centers for Disease Control and Prevention;
    - The Agency for Health Care Research and Quality;
    - The Centers for Medicare & Medicaid Services;
    - Cooperative group or center of any of the entities above or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - Any of the following if the conditions described in paragraph (2) are met: The Department of Veterans Affairs, The Department of Defense or The Department of Energy.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(ii) *Life-threatening Condition.* Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) *Qualified Individual.* An individual who is a participant or beneficiary in the Plan who has coverage under the Plan and who meets the following conditions:

- The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

- Either:
    - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in the paragraph above; or

- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in the paragraph above.

(iv) *Routine Patient Costs.* All items and services consistent with coverage provided under the Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. The term "Routine Patient Costs" does not include: 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or 3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

b. Coverage. Effective July 1, 2014, for Qualified Individuals provided coverage under the Plan, the Plan:

(i) May not deny the individual participation in an Approved Clinical Trial, as defined in Subsection a.(i) above;

(ii) Subject to subsection (c), may not deny, limit or impose additional conditions on, the coverage of Routine Patient Costs for items and services furnished in connection with participation in the trial; and

(iii) May not discriminate against the individual on the basis of the individual's participation in such trial.

c. Use of In-Network Providers. If one or more participating providers is participating in the clinical trial, nothing in subsection b. above shall prevent the Plan from requiring that a Qualified Individual participate in the trial through such participating providers if the provider will accept the individual as a participant in the trial.

d. Use of Out-of-Network Providers. Paragraph c. above shall not apply to a Qualified Individual participating in an approved clinical trial that is conducted outside the State in which the Qualified Individual resides. Such approved clinical trial shall be subject to Paragraph b. above.

e. Limitations on Coverage. This section III.E.5 shall not be construed to require the Plan to cover Routine Patient Costs provided outside of the Plan's network unless out-of-network benefits are otherwise provided under the Plan.

24. Section III.E.6. **Protection from Surprise Bills** is hereby added to read as follows:

a. Effective July 1, 2015, a surprise bill is a bill you receive for covered services:

(i) performed by a non-participating physician at a participating Hospital or Ambulatory Surgical Center, when:

- A participating physician is unavailable at the time the health care services are performed;
- A non-participating physician performs services without your knowledge; or
- Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and you elected to receive services from a non-participating Physician.

(ii) You were referred by a participating physician to a non-participating provider without your explicit written consent acknowledging that the referral is to a non-participating provider and it may result in costs not covered by the Plan.

b. You will be held harmless for any non-participating Physician charges for the surprise bill that exceed your In-Network copayment, deductible or coinsurance if you assign benefits to the non-participating Physician in writing. In such cases, the non-participating Physician may only bill you for your In-Network copayment, deductible or coinsurance.

25. Section III. F. 1. **Description of Preferred Provider Organization Benefit** is modified to add the following at the end of the Preventive Services section:

Note that cost sharing (copays, deductibles and coinsurance) may apply if a preventive service is provided during an office visit when the preventive service is not the primary purpose of the visit. A complete list of the Covered preventive services is available at http://www.uspreventiveservicestaskforce.org/recommendations.htm or will be mailed to you upon request by contacting Chautauqua County School Districts' Medical Health Plan, 7 W. Third Street, Jamestown, New York 14701 Attn: Benefits Consultant.

26. Section III. F. 3. b. **Inpatient Hospital Care (PPO)** is modified to add the following at the end of the section:

- End of Life Care. If you are diagnosed with advanced cancer and you have fewer than 60 days to live, the Plan will cover acute care provided in a licensed Article 28 facility or acute care facility that specializes in the care of terminally ill patients. Your attending physician and the facility's medical director must agree that your care will be appropriately provided at the facility. If the Plan disagrees with your admission to the facility, the Plan will have the right to initiate an expedited appeal to an external appeal agent. The Plan will cover and reimburse the facility for your care, subject to any applicable limitations in this Summary Plan Description until the external appeal agent renders a decision in the Plan's favor.

The Plan will reimburse Non-Participating Providers for this end of life care as follows:

- The Plan will reimburse a rate that has been negotiated between the Plan and the Provider.

- If there is no negotiated rate, the Plan will reimburse acute care at the facility's current Medicare acute care service rates, or

- If it is an alternate level of care, the Plan will reimburse at 75% of the appropriate Medicare rates.

- Limitations/Terms of Coverage. When you are receiving inpatient care in a hospital or other facility as described above, the Plan will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies you take home from the facility. The Plan does not cover radio, telephone and television expenses, or beauty or barber services.

27. Section III.F.3.k. **Physicals (PPO)** is modified as follows:

In net-work, after a $10 copayment, the Plan pays 100% of covered charges, without a deductible, for comprehensive adult routine physicals that are not conducted during a well care visit. You will be responsible for the entire cost if the physical is provided by an out of network provider.

Adult physical exams conducted during well care visits by an in-network provider in accordance with the Health Resources and Services Administration guidelines or United States Preventative Services Task Force guidelines are not subject to a copay, coinsurance or deductible.
A comprehensive adult routine physical or adult well care visit is covered once every calendar year, regardless of whether 365 days have elapsed.

28. Section III. F. 3. s. **Well-Child Care (PPO)** is modified to add the following:

The Plan covers well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan covers preventive care and screenings as provided for in the comprehensive guidelines supported by Health Resources and Services Administration and items or services with an "A" or "B" rating from the United States Preventive Services Task Force. If the schedule of well-child visits referenced above permits one well-child visit per calendar year, we will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as required by ACIP are also covered. This benefit is provided to members from birth through attainment of age 19 and is not subject to copayments, deductibles or coinsurance when provided by a Participating Provider.

29. Section III. F. 3. t. (6) **Additional Covered Services (PPO)** is modified to add a new third bullet as follows:

- Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow up of breast cancer) are unlimited and are covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to deductibles and coinsurance.

30. Section III. F. 3. t. (11) **Other Services (PPO)** is modified to add the following:

The Plan pays 100% of covered charges for the following health care services for women when provided in network and when the services have a rating of A or B in the current recommendations of the United States Preventive Services Task Force, are recommended by the Advisory Council on Immunization Practices, or are included in Health Resources and Services Administration Guidelines:

- Screening for Gestational Diabetes
- Hepatitis B screening (pregnant women only)
- HIV screening and counseling
- Human Papillomavirus (HPV) testing
- FDA approved contraceptive methods and counseling (refer to the Plan's Contraceptive Drugs and Devices Rider)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies, and counseling

31. Section III. F. 3. t. **Additional Covered Services (PPO)** is modified to add the following at the end of the section:

(12) Diagnosis and Treatment of Autism Spectrum Disorder.

We cover the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- Screening and Diagnosis. We cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- Assistive Communication Devices. We cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we cover the rental or purchase of assistive communication devices

when ordered or prescribed by a licensed physician or a licensed psychologist if you are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

Repair, replacement fitting and adjustments of such devices are covered when made necessary by normal wear and tear or significant change in your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered. Coverage will be provided for the device most appropriate to your current functional level. We will not provide coverage for delivery or service charges or for routine maintenance.

- Behavioral Health Treatment. We cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We cover applied behavior analysis when provided by an applied behavior analysis provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

  Effective January 1, 2014, our coverage of applied behavior analysis services is limited to 680 hours per covered member per Plan year.

- Psychiatric and Psychological Care. We cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.

  Therapeutic Care. We cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise covered under this Plan.

- Pharmacy Care. We cover prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Plan.

  Limitations. We will not cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Plan for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed physician or licensed psychologist.

  You are responsible for any applicable deductible, copayment, or coinsurance provisions under this Plan for similar services. For example, any deductible, copayment, or coinsurance that applies to physical therapy visits generally will also apply to physical therapy services covered under this benefit; and any deductible, copayment, or coinsurance for prescription drugs generally will also apply to prescription drugs covered under this benefit. Any deductible, copayment, or coinsurance that applies to office visits will apply to assistive communication devices covered under this paragraph.

  Nothing in this Plan shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

  (13) Chemotherapy.

Chemotherapy is covered in an outpatient facility or a health care professional's office. Orally-administered anti-cancer drugs are covered under the Prescription Drug section of this Plan.

32. Section III. F. 4. **Pregnancy and Maternity (PPO)** is modified to add the following at the end of the section:

In addition, maternity care coverage includes comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and includes costs for renting breastfeeding equipment.

33. Section III.F.5 **Participation in Clinical Trials (PPO)** is added to read as follows:

a. Definitions. As used in this Section III.F.5, the following terms shall have the meanings set forth below:

(i) *Approved Clinical Trial.* A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following paragraphs:

Federally Funded Trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- The National Institutes of Health;
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- Cooperative group or center of any of the entities above or the Department of Defense or the Department of Veterans Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- Any of the following if the conditions described in paragraph (2) are met: The Department of Veterans Affairs, The Department of Defense or The Department of Energy.

The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

(ii) *Life-threatening Condition.* Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(iii) *Qualified Individual.* An individual who is a participant in the Plan who has coverage under the Plan and who meets the following conditions:

- The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

  Either:
  - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in the paragraph above; or

  - the individual provides medical and scientific information establishing that the individual's participation in such trial would

be appropriate based upon the individual meeting the conditions described in the paragraph above.

(iv) *Routine Patient Costs.* All items and services consistent with coverage provided under the Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. The term "Routine Patient Costs" does not include the cost of: 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or 3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

b. Coverage. Effective July 1, 2014, for Qualified Individuals provided coverage under the Plan, the Plan:

(i) May not deny the individual participation in a clinical trial, as defined in Section a.(i) above;

(ii) Subject to subsection (c.), may not deny, limit or impose additional conditions on, the coverage of Routine Patient Costs for items and services furnished in connection with participation in the trial; and

(iii) May not discriminate against the individual on the basis of the individual's participation in such trial.

c. Use of In-Network Providers. If one or more participating providers is participating in the clinical trial, nothing in subsection b above shall be construed as preventing the Plan from requiring that a Qualified Individual participate in the trial through such participating providers if the provider will accept the individual as a participant in the trial.

d. Use of Out-of-Network Providers. Paragraph c. above shall not apply to a Qualified Individual participating in an approved clinical trial that is conducted outside the State in which the Qualified Individual resides. Such approved clinical trial shall be subject to Paragraph b. above.

e. Limitations on Coverage. This section III.F.5 shall not be construed to require the Plan to cover Routine Patient Costs provided outside of the Plan's network unless out-of-network benefits are otherwise provided under the Plan.

34. Section III.F.6. **Protection from Surprise Bills** is added to read as follows:

a. Effective July 1, 2015, a surprise bill is a bill you receive for covered services:

(i) performed by a non-participating physician at a participating Hospital or Ambulatory Surgical Center, when:

- A participating physician is unavailable at the time the health care services are performed;

- A non-participating physician performs services without your knowledge; or

- Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and you elected to receive services from a non-participating Physician.

(ii) You were referred by a participating physician to a non-participating provider without your explicit written consent acknowledging that the referral is to a non-participating provider and it may result in costs not covered by the Plan.

b. You will be held harmless for any non-participating Physician charges for the surprise bill that exceed your In-Network copayment, deductible or coinsurance if you assign benefits to the non-participating Physician in writing. In such cases, the non-participating Physician may only bill you for your In-Network copayment, deductible or coinsurance.

35. Section III.G.2. is amended to revise the seventh bullet to read as follows:

- Research or experimental procedures including services and equipment, unless such procedures meet the requirements for an Approved Clinical Trial as defined in Sections III.D.5, III.E.5 and III.F.5. of this Plan.

36. Section IV. B. **Prescription Drug Exclusions** is modified to add the following at the end of the fourth bullet:

If Vitamin D is prescribed in accordance with United States Preventive Services Task Force guidelines, it is covered and no copay or coinsurance applies if the prescription is filled in-network.

37. Section IV. C. **Prescription Drugs Requiring Prior Authorization** is modified to add the following:

Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells. The copay, coinsurance or deductible amount that applies to orally-administered anti-cancer drugs is the lesser of the amount specified in Section IV.A.1. or the copay, coinsurance or deductible amount, if any, that applies to covered intravenous or injectable chemotherapy agents.

38. Section VII.B.3. **External Appeal** is deleted in its entirety and replaced with the following:

i. Your Right to an External Appeal.

In some cases, you have a right to an external appeal of a denial of coverage. If the Plan has denied coverage on the basis that a service does not meet the Plan's requirements for Medical Necessity (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you or your representative may appeal that decision to an external appeal agent, an independent third party certified by the State to conduct these appeals.

In order for you to be eligible for an external appeal you must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Plan; and

- In general, you must have received a final adverse determination through the Plan's internal appeal process. But, you can file an external appeal even though you have not received a final adverse determination through the Plan's internal appeal process if:

    - The Plan agrees in writing to waive the internal appeal. The Plan is not required to agree to your request to waive the internal appeal; or

    - You file an external appeal at the same time as you apply for an expedited internal appeal; or

    - The Plan fails to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and the Plan demonstrates that the violation was for good cause or due to matters beyond the Plan's control and the violation occurred during an ongoing, good faith exchange of information between you and the Plan).

ii. Your Right to Appeal a Determination that a Service Is Not Medically Necessary.

If the Plan has denied coverage on the basis that the service does not meet the Plan's requirements for Medical Necessity, you may appeal to an external appeal agent if you meet the requirements for an external appeal in paragraph (i) above.

iii. Your Right to Appeal a Determination that a Service is Experimental or Investigational.

If the Plan has denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), you must satisfy the two requirements for an external appeal in paragraph (i) above and your attending Physician must certify that your condition or disease is one for which:

- Standard health services are ineffective or medically inappropriate; or

- There does not exist a more beneficial standard service or procedure covered by the Plan; or

- There exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation – your attending physician should contact the State for current information as to what documents will be considered or acceptable); or

- A clinical trial for which you are eligible (only certain clinical trials can be considered); or

- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease, and such benefit outweighs the risk of the service. In addition, your attending physician must certify that your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

iv. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on the Plan's failure to adhere to claim processing requirements, you have four (4) months from such failure to file a written request for an external appeal.

The Plan will provide an external appeal application with the final adverse determination issued through the Plan's internal appeal process or the Plan's written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the State will forward the request to a certified external appeal agent.

You can submit additional documentation with your external appeal request. If the external appeal agent determines that the information you submit represents a material change from the information on which the Plan based its denial, the external appeal agent will share this information with the Plan in order for the Plan to exercise the Plan's right to reconsider its decision. If the Plan chooses to exercise this right, the Plan will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited external appeal (described below), the Plan does not have a right to reconsider its decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician, or the Plan. If the external appeal agent requests additional information, it will have five (5) additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two (2) business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two (72) hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must notify you and the Plan by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns the Plan's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, the Plan will provide coverage subject to the other terms and conditions of this Summary Plan Description. Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the cost of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be covered under this Summary Plan Description for non-investigational treatments provided in the clinical trial.

The external appeal agent's decision is binding on both you and the Plan. The external appeal agent's decision is admissible in any court proceeding.

The Plan will charge you a fee of $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. The Plan will waive the fee if the Plan determines that paying the fee would be a hardship to you. If the external appeal agent overturns the denial of coverage, the fee will be refunded to you.

v. Your Responsibilities.

It is your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within four (4) months of either the date upon which you receive a final adverse determination, or the date upon which you receive a written waiver of any internal appeal, or the Plan's failure to adhere to claim processing requirements. We have no authority to extend this deadline.

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