**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF ILLINOIS**

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| JAMES DOE and SUSAN DOE, individually and as guardians of JOHN DOE<br><br>Plaintiffs,<br><br>v.<br><br>UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF DEFENSE, ASHTON B. CARTER, Secretary of Defense, DEFENSE HEALTH AGENCY, TRICARE, and HEALTH NET FEDERAL SERVICES, LLC<br><br>Defendants. | ) | Civil No. 3:16-cv-640 |

Plaintiffs James Doe, Susan Doe, and John Doe respectfully state and allege as follows:

## PRELIMINARY STATEMENT

1. John Doe, the son of a colonel in the United States Armed Forces, is a transgender boy, who relies on TRICARE, as administered by Health Net Federal Services, LLC ("Health Net"), for his health insurance coverage. TRICARE[1] is the health care program for Uniformed Service members of the United States military and their families around the world.

2. Based on a visual examination, John was assigned female at birth, but since the age of two, he has asserted that he is male. The incongruence between John's assigned gender at birth and his affirmed gender has caused him severe and unremitting emotional pain. As a result, John was diagnosed with gender dysphoria.

3. Unsure of how to respond to John's insistent, consistent, and persistent assertions that he is male, Susan and James initially thought it might be a phase. For years, Susan and

[1] Reference to "TRICARE" or "Health Net" is made throughout this Complaint; however, on information and belief, the United States and the Department of Defense, Secretary Ashton Carter at all times through the Defense Health Agency maintain authority, direction, and control over the administration of TRICARE, and are therefore implicated to the same extent.

James attempted to dress John in typical female clothing, but were met with significant resistance. Starting to recognize that this was not a phase, Susan and James began educating themselves about the needs of children with gender dysphoria. After reading about gender dysphoria in children and meeting with a psychologist, Susan and James assisted John in transitioning to live as a boy as one means to treat his gender dysphoria. Following John's transition, Susan and James watched John transform from being a sad, anxious child who isolated himself in social settings to one who is happy, confident, outgoing, and social.

4. Consistent with the applicable standards of medical care, John began seeing a doctor to determine when it would be appropriate to begin a regimen of puberty-delaying medication to help reduce the psychological distress caused by developing unwanted secondary sex characteristics due to puberty and to treat this serious medical condition. Puberty-delaying medication is the only safe and effective treatment for adolescents with gender dysphoria. The purpose of this treatment is to provide a young person an opportunity to explore future treatment options for their gender dysphoria without the distress of developing the permanent, unwanted physical characteristics associated with their assigned gender. The effects of the medication are fully reversible. In contrast, the bodily changes associated with puberty can never be fully reversed and, if allowed to develop, will have a permanent, negative effect on the young person's future treatment options and quality of life.

5. John's endocrinologist, Dr. David Dempsher, sought prior authorization for Supprelin, a commonly used puberty-delaying medication. Coverage for the Supprelin was denied on March 28, 2016, based on TRICARE's categorical exclusion of "[a]ll services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under [TRICARE]. This exclusion includes, but is not limited to,

psychotherapy, prescription drugs, and intersex surgery." 32 C.F.R. § 199.4(e)(7); TRICARE Policy Manual, Ch. 1, § 1.2. The pharmacy that fills prescriptions for TRICARE then sought over $30,000 in reimbursement for the medication. The Doe family was eventually allowed to return the Supprelin without charge, but still needed a puberty-delaying medication for John that would not put them in financial ruin and avert the serious harms John would experience if he had to go through puberty.

6. Dr. Dempsher subsequently sought prior authorization for Vantas, which is nearly identical to Supprelin, but is significantly less expensive. TRICARE denied that request on May 18, 2016. However, instead of returning the medication, the Doe family purchased the Vantas implant for John to use when Dr. Dempsher recommended beginning puberty-delaying medication. The Doe family paid $3,607.50 for the medication, not including any costs associated with inserting the implant into John's arm or associated doctor's visits. Additionally, not ten days later, TRICARE denied a request for renewed coverage for Dr. Dempsher's vital services.

7. TRICARE continues to enforce its categorical exclusion of treatment for gender dysphoria despite knowing that transition-related care, such as puberty-delaying medication, is the standard of care for adolescents with gender dysphoria. TRICARE's unwarranted exclusion is based on outdated, unscientific, and prejudicial ideas about transgender people and the medical care they need.

8. Recognizing the importance of starting the puberty-delaying medication in a timely manner, Susan and James decided to cover the cost of the medication and seek reimbursement to avoid any delay in treatment. Without the drug, John would have experienced severe emotional distress and bodily changes that could cause permanent damage to his health and wellbeing.

9. Around this same time, TRICARE also relied upon its discriminatory exclusion for transition-related care to reverse course and begin refusing coverage for John's endocrinology appointments, because they are part of his treatment for gender dysphoria. TRICARE refused coverage despite previously approving coverage for those visits in 2012, 2013, and 2014. It was only in 2015 that TRICARE abruptly reversed course, not only beginning to deny coverage based on the categorical exclusion, but also demanding repayment for the benefits paid in previous years.

10. TRICARE has also reversed course and refused coverage for Susan and James's visits to a psychologist to help guide them in supporting John's transition. The visits to the psychologist significantly helped the family navigate John's transition and understand the various issues that may arise for a transgender child. Once again, TRICARE initially provided coverage for the visits, then unexpectedly demanded that John's family reimburse TRICARE for those benefits.

11. As a result, John's family was forced to pay out of pocket for John's puberty-delaying medication and appointments with healthcare providers to address John's gender dysphoria.

12. TRICARE's decisions and the policies that underlie these decisions violate Section 1557 of the Patient Protection and Affordable Care Act ("Section 1557"), and the equal protection and substantive due process guarantees of the Fifth Amendment to the United States Constitution.

13. Both the Department of Defense and other federal agencies have recognized that blanket exclusions for transition-related care, like that in the TRICARE Policy Manual, are outdated, unsupportable, and discriminate against transgender people on the basis of gender

identity and disability. The Department of Defense has proposed a rule that would "remove the categorical exclusion on treatment of gender dysphoria." That position is consistent with other federal agencies that provide health care services or administer and regulate health care plans.

14. John and his family cannot and should not have to wait while a determination is made on whether to finalize the proposed rule, and if so, in what form. The current policy is discriminatory and prohibited by federal statutory and constitutional law.

15. John and his family seek both money damages sufficient to cover the medication and visits TRICARE has refused to cover and a declaration that TRICARE's policies violate Section 1557 and the individual protections afforded by the Fifth Amendment and are therefore invalid.

16. John and his family also seek injunctive relief permanently enjoining TRICARE from discriminating against John and his family on the basis of John's gender identity.

17. Finally, John and his family seek an invalidation of the discriminatory, illegal, and unconstitutional TRICARE policies that underlie the categorical exclusion of gender dysphoria as a covered diagnosis for treatment.

## THE PARTIES

18. Plaintiff John Doe is a ten-year-old transgender boy. John resides in southern Illinois with his parents and brings this action through his mother, Susan Doe, and father, James Doe.

19. Plaintiff James Doe is an officer of the United States military with a twenty-seven year history of exemplary service. Because of James's service to this country, James, John, and Susan receive healthcare coverage through TRICARE. James resides in southern Illinois with Susan and John.

20. Plaintiff Susan Doe is John's mother. Susan also resides in southern Illinois with her family.

21. Defendant Ashton B. Carter is the Secretary of Defense to the United States, and pursuant to 5 U.S.C. § 702 is in charge of the administration of TRICARE. As such, he is under a duty to ensure that TRICARE is administered properly and in accordance with the Constitution and laws of the United States. Defendant Carter maintains the ultimate authority, direction, and control over the Department of Defense, including the TRICARE health benefits program. Defendant Carter is sued in his official capacity.

22. Defendant the United States Department of Defense, located at 1400 Defense Pentagon, Washington, DC 20301-1400, is an agency of the United States government. The Defense Health Agency is a support agency within the Department of Defense, which administers the TRICARE health care program under the authority delegated to it by the Secretary of Defense.

23. Defendant United States is named as a defendant pursuant to 5 U.S.C. §§ 702-703, because this is an action for judicial review of agency actions that have affected Plaintiffs adversely.

24. Defendant TRICARE is the health care program that covers John, James, and Susan. The administration of TRICARE is based out of the Defense Health Agency.

25. Defendant Defense Health Agency, located at 7700 Arlington Boulevard, Suite 5101, Falls Church, Virginia 22042-5101, is the organization within the Department of Defense that is charged with management responsibility for the TRICARE Health Plan.

26. Defendant Health Net Federal Services, LLC is the third-party administrator for TRICARE benefits in the North Region, which includes Illinois. On information and belief,

Health Net is a corporation organized and existing under the laws of the Commonwealth of Virginia, with a registered agent at 4701 Cox Road, Suite 285, Glenn Allen, Virginia 23060.

## JURISDICTION AND VENUE

27. The present action arises out of, *inter alia*, Defendants' final agency actions denying health care coverage to Plaintiffs and seeking reimbursement for benefits previously paid to Drs. Dempsher and Rosen in violation of 42 U.S.C. § 18116 and the Due Process Clause of the Fifth Amendment of the United States Constitution.

28. Subject matter jurisdiction is proper under 28 U.S.C. § 1331.

29. The Administrative Procedure Act ("APA") provides for judicial review of final agency actions under 5 U.S.C. § 701, *et seq.*

30. Venue is appropriate in the Southern District of Illinois under 28 U.S.C. § 1391(e).

## STATEMENT OF FACTS

### I. Gender Identity Development and Gender Dysphoria

31. Gender identity is a person's inner sense of belonging to a particular gender, such as male or female. It is a deeply felt and core component of human identity. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 451 (5th ed. 2013) (hereinafter "DSM-5"). Everyone has a gender identity, and for most people, their gender identity is consistent with the gender they were assigned at birth. Transgender people have a gender identity, or affirmed gender, that is different from the gender they were assigned or assumed to be at birth.

32. At birth, infants are classified as male or female based on a cursory observation of their external genitalia. This classification becomes the person's birth-assigned gender, but may not be the same as the person's gender identity. Children typically become aware of their gender

identity between the ages of two and four years old. DSM-5 at 455. Around this age, transgender children often begin to express their cross-gender identification to their family members and caregivers through statements (*e.g.*, "I was born in the wrong body"; "I have a girl brain and a boy body") and actions (*e.g.*, dressing up and engaging in activities in a manner consistent with their gender identity). The medical diagnosis of gender dysphoria refers to the severe and unremitting emotional pain resulting from this incongruity. People diagnosed with gender dysphoria have an intense and persistent discomfort with the primary and secondary sex characteristics of their assigned gender. Gender dysphoria is a serious medical condition codified in the DSM-5 and the World Health Organization's International Classification of Diseases.

33. The way in which a child with gender dysphoria expresses himself or herself differs greatly from children engaging in age-appropriate imaginative play; children expressing a gender identity that is different than their assigned gender exhibit a strong cross-gender identification that is insistent, persistent, and consistent. Although uncommon, a gender identity that is inconsistent with one's gender assigned at birth is a normal variation of human diversity.

34. Gender dysphoria was previously referred to as gender identity disorder. The American Psychiatric Association changed the name and diagnostic criteria for this condition to reflect that gender dysphoria "is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se." DSM-5 at 451.

35. When provided with the love, support, and affirmation that all children need, transgender children thrive and grow into healthy adults who have the same capacity for happiness, achievement, and contributing to society as others. For these youth, that means

supporting their need to live in a manner consistent with their gender identity, as opposed to their assigned gender, which may include access to appropriate medical treatment to relieve the distress associated with gender dysphoria.

36. When parents and caregivers discourage or do not allow a child to express cross-gender identification, or do not validate or accept the child's gender identity, the child experiences psychological distress. The child can internalize that distress, causing the child to suppress his or her gender identity and become introverted, or externalize it, resulting in the child developing behavioral issues. In either scenario, rejection or disapproval by the child's parents, family, and caregivers leads to serious mental health consequences for the child, marked by symptoms such as low self-esteem, anxiety, depression, self-harming behaviors, and suicidal ideation.

37. These harmful symptoms interfere with the child's healthy development across all domains. As a result, a child whose gender identity is not affirmed will likely have difficulty developing and maintaining healthy interpersonal relationships with family as well as peers. Similarly, once that child enters school, the lack of familial support can have a detrimental effect on the child's ability to focus in class and learn.

38. The longer these symptoms are allowed to persist without addressing the underlying gender dysphoria, the more significant and long-lasting the negative consequences can become. For example, a recent survey of transgender people revealed *forty-six percent* of transgender men had previously attempted suicide, a rate that is more than twenty-five times the national average. Ann P. Haas, *et al.*, *Suicide Attempts among Transgender and Gender Non-Conforming Adults*, The Williams Institute 2 (2014); Jaime M. Grant, *et al.*, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 82 (2011); *see also*

Arnold H. Grossman, *et al.*, *Transgender Youth and Life-Threatening Behaviors*, 37 Suicide & Life-Threatening Behavior 527, 533-537 (2007). The National Transgender Discrimination Survey found that over one quarter of respondents used drugs and alcohol to cope with the mistreatment they experienced based on their gender identity. Grant, *supra*, at 81; *see also* Caitlyn Ryan, *Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender Children* 5-7 (2009).

39. Part of affirming a transgender child's gender identity is ensuring that the child has access to treatment for their gender dysphoria, namely undergoing a gender transition in order to alleviate the distress caused by gender dysphoria and to live in alignment with their core gender identity.

40. The goal of treatment is to enable a transgender person to live authentically, based on their core gender identity, and typically involves bringing the person's body and social presentation into alignment with the person's gender. Treatment does not make a transgender person more of a man or more of a woman; rather, the person's gender identity already exists. Treatment creates more alignment between the person's identity and their appearance, attenuating the dysphoria and symptoms.

41. Health care providers recognize that when a child has strong and persistent cross-gender identification, which is typically associated with gender dysphoria, "social transition" improves that child's mental health and reduces the risk that the child will engage in self-harming behaviors. Kristina Olson, *et al.*, *Mental Health of Transgender Children who are Supported in Their Identities*, 137 Pediatrics 1 (2016). Social transition involves changes that bring the child's outer appearance and lived experience into alignment with their affirmed gender. That includes wearing clothes, using a name and pronouns, and interacting with peers

and one's social environment in a manner that matches the child's affirmed gender. For most children, living and interacting with others consistently with their lived experience of who they are provides tremendous and immediate relief, because prior to puberty, there are few, if any, observable differences between boys and girls apart from the social and cultural conventions such as dress or hairstyle which, while distinct, children can adopt regardless of their birth-assigned gender.

42. Regardless of whether a child has socially transitioned or not, children with strong and persistent cross-gender identification typically experience a significant level of distress leading up to the start of puberty. That distress is caused by the realization that their bodies will begin to develop secondary sex characteristics that are inconsistent with their gender identity. Those secondary sex characteristics are not only regular reminders of the incongruence between their gender identity and physical body, but also are observable differences that mark that person as male or female to others, including peers.

43. Around the onset of puberty, transgender youth often take special precautions to hide their developing bodies with the hope of presenting to the outside world a body that is consistent with their gender identity. For example, transgender boys use clothing and other materials to flatten the contours of their chest. Those materials can be tight, constricting, and uncomfortable. The physical discomfort these articles cause can add to a young person's overall level of distress; however, the distress and discomfort caused by not taking those additional precautions far outweighs the drawbacks.

44. To alleviate what might otherwise be incapacitating distress and give a young person the opportunity to develop a strong, positive sense of self, health care providers have developed a standard of care for delaying pubertal development in children experiencing gender

dysphoria. Drawing from more than thirty years of experience using puberty-delaying medication in children with precocious puberty (a condition in which a child begins puberty too soon), doctors prescribe those same medications when appropriate to delay the puberty of children with gender dysphoria.

45. Accepted evidence-based standards of care recognize that puberty-delaying medications are medically necessary and the only safe and effective treatment for delaying puberty in transgender youth. For example, the Endocrine Society, a professional organization devoted to research on hormones and the clinical practice of endocrinology, and the World Professional Association for Transgender Health, an international multidisciplinary professional association to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, both support use of puberty-delaying medications in transgender adolescents.

46. This class of puberty-delaying medications, also known as gonadotropin-releasing hormone analogues (hereinafter "GnRH analogues"), signal to a person's body not to produce pubertal hormones (*i.e.* testosterone or estrogen), effectively stopping pubertal development at its source. As a result, GnRH analogues prevent a transgender boy from developing breasts, feminine facial features, and beginning menstruation, among other unwanted secondary sex characteristics and effects of puberty. The standard of care recommends administering GnRH analogues at the onset of puberty, which prevents a young person from experiencing the physical and psychological distress described above.

47. The effects of these puberty-delaying medications are entirely reversible with no long-term consequences. If a young person stops taking these medications, his or her body will

begin pubertal development within six months. In contrast, the effects of permitting puberty to proceed can never be fully reversed.

48. Pubertal development occurs incrementally in what are called "Tanner Stages." There are a total of five Tanner Stages, and all children start in Tanner I. The initial rush of pubertal hormones that marks the beginning of puberty is defined as Tanner II. In addition to hormonal changes, Tanner II is identified by physical changes, particularly breast budding or testicular enlargement. The standards of care call for health care providers to prescribe the GnRH analogues as soon as a child begins Tanner II to halt any further pubertal development. If started early enough, GnRH analogues will not only prevent menstruation, but also may cause the breast buds to recede.

49. GnRH analogues act as a "pause button" on a young person's pubertal development, giving the person the opportunity to explore future treatment options for their gender dysphoria without the distress of developing the permanent, unwanted physical characteristics of their birth-assigned gender. During this time, the young person will work with his or her family and health care providers to develop a treatment plan to address the child's gender dysphoria that is tailored to that person's needs.

50. The use of GnRH analogues to delay puberty in youth experiencing gender dysphoria is the only known safe and effective treatment for gender dysphoria. Mental health services and psychotropic medications alone are not sufficient to avert the serious psychological damage caused by requiring a young person with gender dysphoria to undergo a puberty that is incongruent with his or her gender identity. Moreover, those services cannot halt the physical changes that underlie the psychological distress. Thus, withholding this treatment is not a neutral option: failure to provide the treatment would result not only in intensified psychological harm

to John, but also in irreversible, unwanted physical changes that would have a permanent negative impact on his later treatment options and quality of life.

**II. John's Transgender Identification**

51. Nearly since the time he was able to speak, John has firmly expressed his knowledge that he is a boy. As he grew, John began to match his appearance and behaviors to his male identity. For instance, after observing his male friend using the bathroom, John made several attempts to urinate while standing, becoming increasingly distressed when his parents grew upset at the mess this made. It was only when John's father demonstrated that it was acceptable for a boy to urinate while sitting down that John's anxiety over using the restroom was somewhat alleviated.

52. John also refused to dress in clothes typically associated with girls, only wearing boys' clothing and underwear. John insisted on wearing a set of boys' swim trunks whenever his family took trips to the beach or the pool, and he took off the UV protective shirt he had been given whenever possible. John's hair was another means with which he could express himself – when his mother relented to his pleas to cut his hair very short, John's self-image significantly improved. John would also stuff his underwear with toilet paper to ensure that strangers would see him as a boy.

53. Because of the way he dressed, John was often addressed as a boy by strangers in public. In response, he asked his mother to call him a male name; when John's mother occasionally slipped and called him by his female name, John would become upset. It became increasingly clear to John's parents that this was not simply a "phase," and that John was not just a "tomboy."

54. In March 2009, Susan was running late to get John to school, and with no clean pants for him to wear, she asked, then begged him to wear a skirt with shorts underneath instead.

As frustrations mounted, John's mother finally shouted, "Just put on the dress! Who cares what you wear?" In tears, John responded, "But mom, I care!" It was at this point that John's family soberly started down the path to affirming John's gender identity, eventually assisting him to transition.

55. John's transition did not occur overnight, nor was it always a smooth process. For example, the summer after John transitioned socially, he joined a swim team. Parents complained about John's use of the male restrooms, and the coach did not want John on the team. Despite John's love of the water and swimming, he quit the team because of the pressure from others.

56. John has similarly been shunned by members of his own extended family, who neither support nor understand John's transition. While John and his parents once had a strong bond with James's parents, the relationship changed when John began his transition. John's paternal grandparents first objected to his change in clothing, and were overtly uncomfortable when John swam in boys' swim trunks. Once he publicly transitioned, John's grandparents nearly cut off all ties with him, which has been painful for both John and his parents.

57. John and his family were similarly turned away from their church after seeking help and refuge in navigating John's transition. Rather than finding support, John's family was told not to encourage or affirm his behavior, and John was barred from using the boys' restroom at the church.

58. Outcast by their church and family members, who had no familiarity with or understanding of transgender people, James and Susan turned to Dr. Dean Rosen, a clinical psychologist, for help. Dr. Rosen provided the guidance that James and Susan needed to learn how to help support John and to work as a team through potential conflicts that surfaced with

non-affirming family members and society. Seeing Dr. Rosen was a vital part of helping John become the confident, happy person he is today.

**III. John's Need for Puberty-Delaying Medication and Further Psychotherapy**

59. Despite his social transition (*e.g.*, his changes in dress and hairstyle), John began to feel distress as he approached puberty. When John begins puberty, he will develop breasts, wider hips, and begin menstruation, a prospect which has caused increasing anxiety for John. In anticipation of puberty, and generally to make sure that John was receiving the proper care, James and Susan started bringing John to an endocrinologist, Dr. David Dempsher, in October 2012.

60. As described *supra* in paragraph 48, pubertal development occurs incrementally in what are known as "Tanner Stages." There are five total Tanner Stages throughout any person's life, and all people begin life and continue through childhood in Tanner Stage I. When a child enters puberty and experiences the attendant physical and hormonal changes associated with puberty, the child is entering Tanner Stage II. For a child born with ovaries, entering Tanner Stage II is typically characterized by breast budding.

61. According to Dr. Dempsher, John is currently entering the beginning phases of Tanner Stage II. John has begun to show concern over the prospect of breast development, and he constantly seeks reassurance from his mother that his breasts have not begun to grow. John has also expressed that he does not want to become pregnant; instead, he wants to be a dad when he gets older. When he was younger, John experienced embarrassment and depression when his parents would accidentally refer to him by his female name in public; today, John is likewise fearful of having intimate details about his body and medical history exposed if he is unable to keep his body in close alignment with his male gender identity.

62. Because of these fears, John's parents sought Dr. Dempsher's professional assistance to not only help educate John and his family in the medical options available, but also to assist in treating John to delay his puberty.

63. In light of the potentially devastating effects that will result if John continues through puberty without treatment, it is crucial that he continue to receive treatment from Dr. Dempsher. Dr. Dempsher's office has become a safe haven for John and his family, as Dr. Dempsher has provided and can continue to provide medical advice and treatment to John throughout this period of change.

## IV. Insurance Exclusions for Transition-Related Health Care Services

64. Beginning in the late 1970s and 1980s, transgender people used various federal laws to obtain legal protection from discrimination and access to medically necessary transition-related care. *See, e.g.*, *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980). In response, the federal government began excluding transgender people from the protections of federal law. *See, e.g.*, 42 U.S.C. § 12221(b)(1); 29 U.S.C. § 705(20)(F)(i). And, the private insurance industry followed suit. On information and belief, it was around this time that Defendant Department of Defense first issued its regulation excluding transition-related care from coverage for military members and their dependents.

65. Until recently, those industry-wide exclusions effectively denied transgender people medically appropriate treatment for gender dysphoria. Recognizing the medical necessity of this care, states and the federal government are now requiring insurance companies to expand coverage for transition-related care. For example, a number of states, including Illinois, have begun to enforce state anti-discrimination laws, which prohibit discrimination on the basis of gender identity, to require insurance companies to remove transition-related care exclusions from

the policies sold within that state. Those changes have applied in both private and public health insurance.

66. On the federal level, the Federal Employees Health Benefits Plan eliminated categorical exclusions from the plans serving federal employees and their dependents, a change that took effect in January 2016. Consistent with that change, the United States Department of Health and Human Services imbedded strong protections for transgender people seeking insurance coverage for transition-related care in its final regulations implementing Section 1557, the non-discrimination provision of the Affordable Care Act. Those regulations expressly define sex discrimination to include discrimination on the basis of gender identity and prohibits entities subject to Section 1557 from "[h]av[ing] or implement[ing] a categorical coverage exclusion or limitation for all health services related to gender transition." 45 C.F.R. § 92.207(b)(4).

67. The TRICARE exclusion of all transition-related care is another vestige of the bygone era where such exclusions were the industry standard. In October 1984, Congress amended the statute pertaining to the scope of coverage for the military health benefits to include exclusions for "[t]herapy or counseling for sexual dysfunctions or sexual inadequacies" and "surgery which improves the physical appearance but is not expected to significantly restore functions," including a reference to "sex gender changes." P.L. 98-525, § 1401(3) (codified as 10 U.S.C. §§ 1079(a)(10) & (12)).

68. Exercising its authority to interpret federal law pertaining to the Department of Defense, on or about July 1986, Defendant Department of Defense issued a final rule excluding "[a]ll services and supplies directly or indirectly related to transsexualism (or such other conditions as gender dysphoria) . . . . This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with

transsexualism or hermaphroditism." 32 C.F.R. § 199.4(e)(7) (1986). That exclusion was also repeated at 32 C.F.R. § 199.4(g)(29) (1986). Both of those exclusions remain codified in the statute and regulations with substantially similar language. 10 U.S.C. § 1079(a)(9) & (11) (2016); 32 C.F.R. §§ 199.4(e)(7) & (g)(29) (2016).

69. That exclusionary language is parroted throughout the Tricare Policy Manual, a manual that details the scope of TRICARE benefits and is used by third-party administrators, such as Defendant Health Net, to make coverage determinations. For example, in the section titled "Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders," the manual states that "[s]ervices and supplies provided in connection with psychotherapy for sexual dysfunctions, Paraphilias, *and gender identify disorders* are specifically excluded from cost sharing. This includes therapy that is wholly or partially related to treating the sexual dysfunctions, paraphilias (*e.g.*, transvestic fetishism) *or gender identity disorder*, such as sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy, or other similar services." TRICARE Policy Manual, Ch. 7, § 1.1(emphasis added).

## V. Defendants' Refusal to Cover Treatment Under TRICARE

70. TRICARE provides health insurance coverage for military personnel, military retirees, and their families, which totals over nine million people worldwide. Defendant Defense Health Agency contracts with third-party administrators, one of which is Health Net, to assist in administering those benefits to members throughout the United States.

71. Under TRICARE, members cannot simply go to a specialist, such as an endocrinologist or clinical psychologist. Rather, the member's Primary Care Manager must first determine whether a particular health care need can be met by the services available on the member's base. When a TRICARE member requires health care services that are only offered off base, the Primary Care Manager must notify the TRICARE administrator for that region.

The third-party administrator then determines what, if any, services the member is permitted to receive based on whether the service is medically necessary, delivered in an appropriate setting, and is a covered TRICARE benefit. This authorization must also be periodically renewed.

72. The Doe family followed this prescribed protocol prior to bringing John to Dr. Dempsher and before Susan and James met with Dr. Rosen. And, consistent with that protocol, the Doe family renewed their approval for those services, when needed. Despite the TRICARE Policy Manual's categorical exclusion of these services, Health Net approved the Doe family's claims for coverage from October 2012 to October 2015. Throughout that three-year span, Defendants never notified the Doe family of the existence of the exclusion.

73. Following the protocol she had established over the previous three years, on October 11, 2015, Susan requested a referral renewal to Dr. Dempsher's office by phone from the Primary Care Physician Nurse. Ex. A. Although all prior requests for coverage had been approved by TRICARE, two days later, on October 13, 2015 the request was unexpectedly denied. Ex. B. For the first time, Health Net cited the exclusion for transition-related care in the TRICARE Policy Manual as the basis for denying coverage.

74. On or about November 2, 2015, Susan appealed that denial through Health Net services. Ex. C. In the appeal, Susan cited two reasons that her request should be granted: (1) the medical care provided by Dr. Dempsher (including the medicine requested) is a medically necessary, safe, and effective treatment for John's gender dysphoria; and (2) continuing to deny such medically necessary care constitutes unlawful discrimination based on John's gender identity. Specifically, Susan cited to Section 1557 in support of her assertion of unlawful discrimination.

75. By letter, dated November 23, 2015, Health Net informed Susan that the denial would be upheld, because Dr. Dempsher's treatment was "not a TRICARE benefit," and reiterating its reliance on the exclusion of all transition-related care in the TRICARE Policy Manual. Ex. D. In its response, the reviewer wrote "while we have determined that the services cannot be covered under TRICARE benefits, we found that there were concerns about the benefits and 'unlawful discrimination' concerns due to benefit denial(s)." *Id*.

76. On November 25, 2015, presumably in recognition of its independent obligation not to discriminate, Health Net wrote a letter to Susan stating that its Grievance Department was considering her "concerns" over the denial of the benefit and would have a completed review within 60 days. Ex. E.

77. On December 22, 2015, TRICARE, through Health Net, issued yet another denial of Susan's appeal, affirming its previously asserted grounds for denial. Ex. F.

78. On January 13, 2016, TRICARE issued a "revised determination letter," reassessing and denying all backdated claims (including John's visits to his endocrinologist, Dr. Dempsher, and his clinical psychologist, Dr. Rosen, dating back to December 5, 2012), again based on the transition-related care exclusion. Ex. G.

79. The Does have appealed each of those denials to the extent permitted under the TRICARE rules and regulations and therefore exhausted their administrative remedies in their effort to challenge the policy leading to the denials of benefits.

80. Most recently, in a letter dated May 27, 2016, TRICARE through Health Net again denied the Does permission to see Dr. Dempsher. As an excuse, the letter cites the same discriminatory language used in past denials from the TRICARE Policy Manual, namely, that

TRICARE excludes "cost share for services and suppliers provided in connection with psychotherapy for sexual dysfunction, paraphilias, and gender identity disorders. . . ." Ex. H.

81. TRICARE's denials of care to John were unwarranted and discriminatory and came at a critical time in John's medical treatment and development. As John was quickly progressing toward puberty, Susan and James first realized that TRICARE would refuse to cover any medically necessary treatment for John's transition, including puberty-delaying medication. As a result of that denial, Susan and James are responsible for paying out of pocket for all of John's care despite having a healthcare plan intended to provide comprehensive coverage to active and retired members of the military and their families. In their time of greatest need, the Doe family would get no support from the government James has faithfully served for nearly thirty years.

82. As John's progression toward puberty continued, Susan and James requested that Dr. Dempsher prescribe the puberty-delaying medication for John so that it would be ready for him when he needed it. On or about March 14, 2016, Dr. Dempsher submitted a prior authorization request for Supprelin, an implant that contains the GnRH analogue, histrelin acetate. On March 31, 2016, again applying the transition-related care exclusion, Health Net denied coverage for the only known, safe and effective treatment for gender dysphoria in adolescents. Ex. I.

83. Desperate to halt the progress of John's puberty, on May 16, 2016, John and his family applied, through Dr. Dempsher, for Vantas, another GnRH analogue, also formulated using histrelin acetate. On May 18, 2016, the claim for coverage was denied by TRICARE when the Does' pharmacy attempted to process the request. Because of the Does' desperate situation,

they had no choice but to bear the burden of paying for the Vantas themselves, costing them $3,607.50 for one implant, which is expected to last approximately twelve months.

84. Despite excluding coverage for GnRH analogues to treat gender dysphoria, TRICARE and Health Net regularly cover those medications for other medical conditions such as precocious puberty, prostate cancer, and endometriosis. The letter denying coverage for Supprelin provides no justification for this difference in coverage other than TRICARE's ban on transition-related care.

85. The unlawfulness of TRICARE's denials of the Does' claims is accentuated by Illinois' own state regulations prohibiting discrimination. Illinois law provides that group health insurance plans "shall not discriminate on the basis of an insured's or prospective insured's actual or perceived gender identity," which includes "provisions that exclude from, limit, charge a higher rate for, or deny a claim for coverage of hospital and medical benefits for gender dysphoria if benefits covered by the policy are provided for other medical conditions." 50 Ill. Adm. Code 2603.35(a)(2). Additionally, all insurers operating in Illinois were explicitly warned over 20 months ago that denials based upon "actual or perceived . . . gender-related identity," such as TRICARE's actions against the Does' here, violated not only Section 1557, but the Illinois Human Rights Act (IHRA) as well. Letter from Andrew Boron (Director of the Illinois Department of Insurance) dated July 28, 2014, attached as Ex. J. While there is no private right of action provided under either Illinois law provision, the prohibition against the specific type of discrimination exhibited by TRICARE here is abundantly clear.

86. In addition to Illinois' rejection of TRICARE's discrimination against people with gender dysphoria, the Department of Defense itself—a named defendant—recently acknowledged that this is a serious legal problem in need of correction. On February 1, 2016,

the Department published a proposed rule change in the Federal Register that would expressly prohibit TRICARE's denials of coverage detailed herein. Specifically, the proposed change reads:

> This rulemaking proposes to ***remove the categorical exclusion on treatment of gender dysphoria***. This proposed change will permit ***coverage of all non-surgical medically necessary and appropriate care in the treatment of gender dysphoria***, consistent with the program requirements applicable for treatment of all mental or physical illnesses. Surgical care remains prohibited by statute at 10 U.S.C. 1079(a)(11).

*See* "A COLA Hike for Some, Transgender Coverage for Others," *Government Executive* (Feb. 3, 2016), *available at* http://www.govexec.com/pay-benefits/pay-benefits-watch/2016/02/cola-hike-some-transgender-coverage-others/125658/ (emphasis added). While it is not clear when, or if, this proposed rule will be finalized, its proposal by the Department indicates not only that the federal government is equally aware of the unlawful and unconstitutional discrimination currently at the heart of TRICARE policy, but that a named defendant admits the relevant policy impermissibly excludes coverage for medically necessary and appropriate care for John and other dependents of military personnel experiencing gender dysphoria.

87. Statements made by Defendant Carter himself support the notion that such government discrimination against transgender persons should end. Calling for a review of the ban on transgender service members in the United States, Defendant Carter was quoted as stating, "We have transgender soldiers, sailors, airmen, and Marines—real, patriotic Americans—who I know are being hurt by an outdated, confusing, inconsistent approach that's contrary to our value of service and individual merit." *See* Travis J. Tritten, "DOD Wants Transgender Tricare Coverage," *Stars and Stripes* (Feb. 1, 2016), *available at* http://www.stripes.com/news/dod-wants-transgender-tricare-coverage-1.391637. John, the child

of a colonel in the United States Air Force, is also being hurt—solely on the basis of his transgender status—by the outdated, confusing, inconsistent approach to medical care applied by Defendants.

**COUNT I**
**(Discrimination Based on Sex in Violation of 42 U.S.C. § 18116)**

88. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 87 above.

89. Section 1557, which is codified at 42 U.S.C. § 18116, provides that:

> Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.) . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under . . . title IX . . . shall apply for purposes of violations of this subsection.

90. The Office of Civil Rights has explicitly stated that Section 1557's prohibition of sex discrimination "extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity." Letter from Leon Rodriguez, Dir. of Office for Civil Rights, Dep't of Health & Human Services, to Maya Rupert, Fed. Pol'y Dir., Nat'l Center for Lesbian Rights (July 12, 2012) (OCR Transaction No. 12-000800); *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *10 (D. Minn. Mar. 16, 2015) (finding the OCR letter from Leon Rodriguez persuasive).

91. On May 13, 2016, the United States Department of Health and Human Services issued its final regulations implementing Section 1557. Those regulations expressly provide that Section 1557's prohibition on sex discrimination includes discrimination on the basis of gender

identity and sex stereotypes, 45 C.F.R. § 92.4, and delineate specific protections to ensure that transgender people are not discriminated against in access to health insurance coverage for transition-related care, 45 C.F.R. § 92.207. In particular, the regulations define the scope of prohibited discriminatory conduct to include: "[h]av[ing] or implement[ing] a categorical coverage exclusion or limitation for all health services related to gender transition;" and "deny[ing] or limit[ing] coverage . . . for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual." 45 C.F.R. §§ 92.207(b)(4), (b)(5). Those regulations are also consistent with Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, *et seq.* and its implementing regulations, which prohibits sex discrimination in education programs that receive federal financial assistance and is referenced as the source of the prohibition on sex discrimination in Section 1557. For example, in *G.G. v. Gloucester County School Board*, the Fourth Circuit reversed the dismissal of a transgender student's Title IX claim for sex discrimination, holding that the United States Department of Education's interpretation of its regulations to include a prohibition against discrimination on the basis of gender identity is entitled to *Auer* deference. --- F.3d ---, 2016 WL 1567467 at *8 (Apr. 19, 2016).

92. The United States Department of Education and Department of Justice further clarified that position on May 13, 2016, releasing joint guidance on Title IX and transgender students. That guidance explicitly stated that that Title IX's prohibition of sex discrimination protects students against discrimination on the basis of gender identity. Failing to comply could jeopardize the school district's federal funds.

93. As a transgender person, John Doe has a right under Section 1557 to receive health care services, including health insurance coverage, free from discrimination based upon gender identity or transgender status.

94. Defendant Department of Defense is an executive agency that, through Defendant Secretary Carter and Defendant Defense Health Agency, administers TRICARE, a health program that is subject to Section 1557.

95. As the third-party administrator of TRICARE, Defendant Health Net is a health program that receives federal financial assistance and is therefore subject to Section 1557.

96. The conduct of Defendants described herein constitutes sex discrimination against Plaintiff on the basis of his gender identity and transgender status in violation of Section 1557. Defendants have and are implementing a categorical exclusion for transition-related care by refusing coverage for GnRH analogues, such as Supprelin, for the treatment of gender dysphoria, where on information and belief, TRICARE covers those medications for other uses. Defendants have also relied on that categorical exclusion to deny coverage for the office visits with Dr. Dempsher, an important part of the protocol for treating gender dysphoria in children and adolescents.

97. Similarly, even if categorical exclusions were not specifically prohibited by Section 1557 and its implementing regulations, TRICARE's ban on coverage for transition-related care also constitutes impermissible discrimination because of its direct discriminatory impact on transgender people. The only individuals who require puberty-delaying medication to treat gender dysphoria are transgender individuals. There is no non-discriminatory reason for excluding this medically necessary care from refusing coverage for transgender people, while covering GnRH analogues to non-transgender people for a variety

of health conditions. Thus, by denying coverage for John, Defendants are inherently discriminating against him because of his gender identity.

98. As a result of these acts of discrimination, Plaintiffs have suffered monetary damages in the form of out of pocket expenses for medically necessary care to treat John's gender dysphoria including, but not limited to, the cost of the Vantas implant and the procedure to insert it into John's arm and doctor's visits with Dr. Dempsher. Moreover, without declaratory relief prohibiting enforcement of TRICARE's categorical exclusion, John will be forced to suffer through the irreversible bodily changes and the negative psychological effects of puberty when the Vantas implant needs to be replaced. Although the Doe family was able to cover the medication and other health care costs to date, continuing to do so on an ongoing basis is beyond the family's financial means.

99. Plaintiffs are therefore entitled to declaratory and injunctive relief, and damages.

**COUNT II**
**(Discrimination Based on Disability in Violation of 42 U.S.C. § 18116)**

100. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 99 above.

101. Section 1557 also prohibits discrimination on the basis of disability by reference to Section 504 of the Rehabilitation Act of 1973 (hereinafter "Section 504").

102. Gender dysphoria is a covered disability under Section 504 under 29 U.S.C. § 705(20)(B). John's gender dysphoria constitutes an impairment that limits one or more major life functions, including, but not limited to, learning, concentrating, interacting with others, and caring for oneself. Without mitigating measures, such as puberty-delaying medication, John's ability to engage in or complete those major life activities would be

substantially impaired as evidenced by the psychological distress he experienced prior to his transition.

103. Although Congress intended to exclude some physical and mental impairments from the definition of disability, none of those exclusions are applicable or enforceable as it pertains to gender dysphoria. *See* 29 U.S.C. § 705(20)(F). In particular, subsection (i) excludes the following conditions from coverage under Section 504: "transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or *other* sexual behavior disorders." 29 U.S.C. § 705(20)(F)(i) (emphasis added). However, since this exclusion was enacted, the understanding of gender dysphoria and transgender people has developed significantly. The diagnostic criteria for gender dysphoria are substantially different from gender identity disorder, and the condition itself is no longer seen as a disorder at all, let alone a disorder of sexual behavior, but instead is correctly viewed as a serious medical condition that, if left untreated, can result in debilitating psychological distress.

104. In addition to falling outside the plain meaning of the statute, Section 705(20)(F)(i) is unenforceable because it was motivated by "a bare congressional desire to harm a politically unpopular group." *U.S. Dep't of Agriculture v. Moreno*, 413 U.S. 528, 534 (1973); *see also Romer v. Evans*, 517 U.S. 620, 634-36 (1996). The legislative history behind the exclusion is replete with evidence of Congress's discriminatory intent to harm transgender people. *See*, *e.g.*, 135 Cong. Rec. S10753 (daily ed. Sept. 7, 1989) (seeking to amend the definition of disability so that it would not include conditions that had a "moral" component). Indeed, the United States has issued a statement of interest in a pending case supporting the position that gender dysphoria is protected under the ADA, a federal law that contains an identical exclusion to the one found at 29 U.S.C. § 705(20)(F). Second Statement of Interest of

the United States at 6, *Blatt v. Cabela's Retail*, No. 5:14-cv-4822-JFL (E.D. Pa. *filed* Aug. 15, 2014) (urging the court to "adopt this proposed construction, under which Plaintiff's gender dysphoria would not be excluded from the ADA's definition of 'disability.'").

105. GnRH analogues are used to treat a number of different conditions, including, but not limited to, precocious puberty, prostate cancer, and endometriosis. TRICARE covers GnRH analogues as treatment for those conditions. However, TRICARE continues to apply its categorical exclusion to deny coverage for GnRH analogues for the treatment of gender dysphoria, even though that treatment constitutes the standard of care and is the only safe and effective treatment for gender dysphoria in adolescence. The conduct of Defendants described herein constitutes disability discrimination against Plaintiff on the basis of his gender dysphoria diagnosis in violation of Section 1557.

106. As a result of these acts of discrimination, Plaintiffs have suffered monetary damages in the form of out of pocket expenses for medically necessary care to treat John's gender dysphoria including, but not limited to, the cost of the Vantas implant and the procedure to insert it into John's arm and doctor's visits with Dr. Dempsher. Moreover, without declaratory relief prohibiting enforcement of TRICARE's categorical exclusion, John will be forced to suffer through the irreversible bodily changes and the negative psychological effects of puberty when the Vantas implant needs to be replaced. Although the Doe family was able to cover the medication and other health care costs to date, continuing to do so on an ongoing basis is beyond the family's financial means.

107. Plaintiffs are therefore entitled to declaratory and injunctive relief, and damages.

**COUNT III**
**(Discrimination Based on Association in Violation of 42 U.S.C. § 18116)**

108. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 107 above.

109. Section 1557 also prohibits associational discrimination. Pursuant to 45 C.F.R. § 92.209, it is impermissible to:

> exclude from participation in, deny the benefits of, or otherwise discriminate against an individual or entity in its health programs or activities on the basis of the race, color, national origin, sex, age, or disability of an individual with whom the individual or entity is known or believed to have a relationship or association.

110. Defendants' enforcement of TRICARE's categorical exclusion denied Susan and James appropriate mental health treatment due to their association with John. Specifically, Susan and James sought the services of Dr. Rosen to assist them in supporting and affirming John's gender identity to help ensure that he develops into a healthy adult. The services that Dr. Rosen provided are regularly covered for parents seeking guidance and support to cope with anxiety and other forms of psychological distress that are interfering with their ability to parent. However, Defendants retroactively denied Susan and James coverage and sought reimbursement for those same services, because they were sought to benefit John, a transgender boy with gender dysphoria.

111. As a result of these acts of discrimination, Plaintiffs have suffered monetary damages in the form of out of pocket expenses for medically necessary care to treat John's gender dysphoria, specifically the cost of Susan and James's appointments with Dr. Rosen. Moreover, without declaratory relief prohibiting enforcement of TRICARE's categorical exclusion, Susan and James will continue to be denied this important health care service to help treat John's gender dysphoria. Although the Doe family was able to cover the health care costs

associated with John's medically necessary treatments for gender dysphoria to date, continuing to do so on an ongoing basis is beyond the family's financial means.

112. Plaintiffs are therefore entitled to declaratory and injunctive relief, and damages.

**COUNT IV**
**(Discrimination on the Basis of Sex in Violation of the Due Process Clause of U.S. Const., amend. V)**

113. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 112 above.

114. The equal protection guarantee which is incorporated in the Due Process Clause of the Fifth Amendment requires the federal government to have a sufficient justification before enforcing laws and policies that treat groups of citizens differently. When those classifications divide, or have the effect of dividing, people on the basis of sex, the government must be able to articulate an "exceedingly persuasive justification" to survive a constitutional challenge. *United States v. Virginia*, 518 U.S. 515, 546 (1996). Moreover, the justification must be "genuine"—reasons that are "hypothesized or invented *post hoc* in response to litigation" will not suffice. *Id.* at 533. This burden "is demanding and it rests entirely on the [governmental entity]." *Id.* In this context, the definition of sex encompasses gender identity and transgender status. *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011).

115. Defendants Department of Defense, Defense Health Agency, and TRICARE are federal governmental entities subject to the United States Constitution.

116. Defendant Health Net is also a governmental actor and subject to the United States Constitution.

117. Defendants' continued enforcement of TRICARE's categorical exclusion for transition-related care denies John Doe healthcare benefits that he otherwise would be entitled to, because he is transgender. The TRICARE Policy Manual permits coverage for GnRH analogues

and mental health services for the treatment of numerous conditions for which that treatment is the standard of care. Defendant's conduct is contrary to the prevailing standards of medical care and denies transgender adolescents coverage for the only known safe and effective treatment for gender dysphoria. Moreover, the decision to deny coverage is grounded in a categorical exclusion whose aim is to harm the transgender community, a politically unpopular group.

118. Defendants' policy—as expressed and enforced through the TRICARE Policy Manual—impermissibly and intentionally discriminates between transgender people in need of the medication at issue and non-transgender patients who need the same medication and treatments.

119. There is no exceedingly persuasive justification furthered by denying access to safe, effective, and medically necessary treatments John needs, where those treatments are regularly covered for the treatment of other conditions. The policy is not even so much as rationally related to a legitimate state interest.

120. This TRICARE policy therefore violates the equal protection guarantees of the Fifth Amendment to the United States Constitution.

121. Plaintiffs are entitled to declaratory and injunctive relief.

**COUNT V**
**(Discrimination on the Basis of Disability in Violation of the Due Process Clause of U.S. Const., amend. V)**

122. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 121 above.

123. Defendants' enforcement of TRICARE's categorical exclusion of transition-related care also constitutes discrimination on the basis of disability. When a governmental entity discriminates on the basis of disability, it cannot justify that discrimination with "irrational prejudice," regardless of whether it is consistent with public opinion. *City of*

*Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 448-50 (1985); *see also Palmore v. Sidoti*, 466 U.S. 429, 433 (1984) ("Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect.").

124. Defendants' policy—as expressed and enforced through the TRICARE Policy Manual—impermissibly and intentionally discriminates between people with gender dysphoria and those seeking coverage for conditions other than gender dysphoria.

125. The policy is not even rationally related to a legitimate state interest, let alone able to survive any higher level of scrutiny. The government furthers no rational interest by denying access to the only safe, effective, and medically necessary treatments John needs, where those treatments are regularly covered for the treatment of other conditions.

126. This TRICARE policy therefore violates the equal protection guarantees of the Fifth Amendment to the United States Constitution on the basis of disability.

127. Plaintiffs are entitled to declaratory and injunctive relief.

**COUNT VI**

**(Violation of Substantive Due Process Afforded by the U.S. Const., amend V)**

128. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 1 through 127 above.

129. The Due Process Clause of the Fifth Amendment places limitations on federal action that deprives individuals of life, liberty, or property.

130. Substantive protections of the Due Process Clause include the right to avoid the disclosure of highly sensitive, personal information.

131. Plaintiff John Doe has a fundamental right to privacy in preventing the release of, and in deciding in what circumstances (if any) to release highly sensitive, personal information

related to his assigned gender at birth, especially as the release of such information would subject him to psychological harm and could additionally expose him to harassment and bodily harm.

132. John and his family have undertaken significant steps to ensure that John's transgender status remains private and prevent even inadvertent disclosure of that information. For example, in addition to obtaining a court-ordered name change for John, Susan and James worked with John's first-grade teacher and administrators to ensure that he was able to transition in a way that was discrete and comfortable for him. Since his transition, the Doe family does not disclose John's transgender status to others, is listed as male on Susan and James's tax returns, and participates in recreational sports, such as hockey, on a boys' team. Susan and James also plan to update John's passport and social security record to reflect the correct gender marker, a step they hesitated to take due to uncertainty of how it may affect insurance coverage for John's transition-related care.

133. If Defendants were permitted to continue enforcing the categorical ban on transition-related care, the Doe family would be financially unable to cover the costs associated with the medically necessary treatment for John's gender dysphoria. Plaintiffs' inability to cover that care will result in John developing unwanted and irreversible secondary-sex characteristics, such as breasts, a feminine appearing face, and wide hips, all of which are inconsistent with John's gender identity and expose the fact that he was assigned female at birth to the public.

134. There is no compelling state interest that is furthered by denying access to the medically necessary treatment Dr. Dempsher has prescribed for John, nor is Defendants' categorical exclusion narrowly tailored or the least restrictive alternative for promoting a state interest. The policy is not even so much as rationally related to a legitimate state interest.

135. Further, Plaintiffs' privacy interests outweigh any purported interest the Defendants could assert.

136. Plaintiffs are therefore entitled to declaratory and injunctive relief.

**PRAYER FOR RELIEF**

WHEREFORE, Plaintiffs respectfully request that this Court:

A. Enter a declaratory judgment that Defendants' denial of coverage for GnRH analogues and related treatment sought to treat gender dysphoria:

1. Violates Section 1557 by impermissibly discriminating against transgender people covered by TRICARE on the basis of sex and disability;

2. Violates Section 1557 by impermissibly discriminating against the family members and caregivers covered by TRICARE on the basis of their association with a transgender person;

3. Violates the guarantee of equal protection under the Fifth Amendment of the United States Constitution by denying safe and effective treatment consistent with the standard of medical care where those same treatments are made available to other groups of patients, and the denial is based on a person's gender identity or gender dysphoria diagnosis; and

4. Violates the Plaintiffs' substantive due process protected by the Fifth Amendment of the United States Constitution.

B. Issue an injunction prohibiting Defendants from enforcement of TRICARE's categorical exclusion for transition-related care unless there is non-discriminatory basis for denying coverage, including prohibiting Defendants from denying Plaintiffs the necessary care to treat Plaintiff John Doe's gender dysphoria, including coverage for GnRH analogues and related treatment;

C. Enter a declaratory judgment that the policies underlying the TRICARE and Health Net decisions to deny prescription of Vantas and Supprelin, and treatment by Drs. Dempsher and Rosen are illegal as invalid and unconstitutional;

D. Award Plaintiffs damages in an amount to be established at trial;

E. Award Plaintiffs reasonable attorneys' fees, costs, and expenses pursuant to 42 U.S.C. § 1988 or other applicable statutes; and

F. Award Plaintiffs such other and further relief as the Court may deem just and proper.

Dated: June 14, 2016

Respectfully submitted,

/s/ Brent P. Ray

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*Attorneys for Plaintiffs*

JS 44 (Rev. 11/15)

# CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

## I. (a) PLAINTIFFS

James Doe and Susan Doe, individually and as guardians of John Doe

**(b)** County of Residence of First Listed Plaintiff _____
*(EXCEPT IN U.S. PLAINTIFF CASES)*

**(c)** Attorneys *(Firm Name, Address, and Telephone Number)*
Brent P. Ray
Kirkland & Ellis LLP
300 N. LaSalle, Chicago IL 60654

## DEFENDANTS

United States of America, et al.

County of Residence of First Listed Defendant _____
*(IN U.S. PLAINTIFF CASES ONLY)*

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

## II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☒ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

## III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

*(For Diversity Cases Only)*

| | PTF | DEF | | PTF | DEF |
|---|---|---|---|---|---|
| Citizen of This State | ☐ 1 | ☐ 1 | Incorporated *or* Principal Place of Business In This State | ☐ 4 | ☐ 4 |
| Citizen of Another State | ☐ 2 | ☐ 2 | Incorporated *and* Principal Place of Business In Another State | ☐ 5 | ☐ 5 |
| Citizen or Subject of a Foreign Country | ☐ 3 | ☐ 3 | Foreign Nation | ☐ 6 | ☐ 6 |

## IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

**CONTRACT**
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

**TORTS**

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

**FORFEITURE/PENALTY**
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

**BANKRUPTCY**
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

**PROPERTY RIGHTS**
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

**OTHER STATUTES**
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

**LABOR**
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

**SOCIAL SECURITY**
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

**REAL PROPERTY**
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

**CIVIL RIGHTS**
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

**PRISONER PETITIONS**

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

**IMMIGRATION**
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

**FEDERAL TAX SUITS**
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

## V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation

## VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
42 USC §§ 18116

Brief description of cause:
Denial of health care coverage

## VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

**DEMAND $**

CHECK YES only if demanded in complaint:
**JURY DEMAND:** ☒ Yes ☐ No

## VIII. RELATED CASE(S) IF ANY

*(See instructions):* JUDGE _____ DOCKET NUMBER _____

DATE
06/14/2016

SIGNATURE OF ATTORNEY OF RECORD
/s/ Brent P. Ray

**FOR OFFICE USE ONLY**

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

Print Save As... Reset

# EXHIBIT A

## Authorizations and Referrals

Health Net Federal Services

Authorization number: [redacted] View claims for this authorization

Patient: [redacted]
DoD Benefits Number: [redacted]
Patient date of birth: [redacted]
Primary diagnosis: GENDR IDENTITY DIS-CHILD
Secondary diagnosis:
Plan: TRICARE PRIME FAMILY COVERAGE FOR ACTIVE DUTY
Sponsor: [redacted]
Sponsor SSN: [redacted]

Begin date of service: 10-02-2012
End date of service: 09-30-2013
Place of service: DOCTOR'S OFFICE
Decision: APPROVED
Reason: APPROVE, MEDICALLY APPROPRIATE

Approved service type: MEDICAL CARE
Approved procedure range:
Beginning procedure: OFFICE/OP VISIT, EST PT, NOT REQUIRING PHYSICIAN PRESENCE, TYPICALLY 5 MIN
Ending procedure: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY.
Quantity: 5 UNITS
Frequency: AS NEEDED

Servicing provider: DAVID P DEMPSHER MD
Specialty: PEDIATRICS
Phone: --

Associated group: ST LOUIS UNIV HOSPITAL SLUCARE
Address: 1465 S GRAND BLVD SAINT LOUIS, MO 63104
Phone: 314-268-4008
Fax: 314-268-4163

Referring provider: SCOTT AFB MEDICAL CLINIC-375TH
Specialty: OTHER
Address: 310 W LOSEY ST SCOTT AIR FORCE BASE, IL 6222
Phone: 618-256-9355
Fax: 618-256-7200

AskUs a question.

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## Authorizations and Referrals

Health Net
Federal Services

Authorization number: [redacted] View claims for this authorization

Patient: [redacted]
DoD Benefits Number: [redacted]
Patient date of birth: [redacted]
Primary diagnosis: GENDR IDENTITY DIS-CHILD
Secondary diagnosis:
Plan: TRICARE PRIME FAMILY COVERAGE FOR ACTIVE DUTY
Sponsor: [redacted]
Sponsor SSN: [redacted]

Begin date of service: 07-16-2013
End date of service: 07-01-2014
Place of service: DOCTOR'S OFFICE
Decision: APPROVED
Reason: APPROVE, MEDICALLY APPROPRIATE

Approved service type: MEDICAL CARE
Approved procedure range:
Beginning procedure: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE
Ending procedure: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYS
Quantity: 5 UNITS
Frequency: AS NEEDED

Servicing provider: DAVID P DEMPSHER MD
Specialty: PEDIATRICS
Phone: --

Associated group: ST LOUIS UNIV HOSPITAL SLUCARE
Address: 1465 S GRAND BLVD SAINT LOUIS, MO 63104
Phone: 314-268-4008
Fax: 314-268-4163

Referring provider: SCOTT AFB MEDICAL CLINIC-375TH
Specialty: OTHER
Address: 310 W LOSEY ST SCOTT AIR FORCE BASE, IL 6222
Phone: 618-256-9355
Fax: 618-256-7200

AskUs a question.

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## Authorizations and Referrals

Health Net Federal Services

Authorization number: [redacted] View claims for this authorization

Patient: [redacted]
DoD Benefits Number: [redacted]
Patient date of birth: [redacted]
Primary diagnosis:
Secondary diagnosis:
Plan: TRICARE PRIME FAMILY COVERAGE FOR ACTIVE DUTY
Sponsor: [redacted]
Sponsor SSN: [redacted]

Begin date of service: 10-28-2014
End date of service: 10-28-2015
Place of service: OUTPATIENT HOSPITAL
Decision: APPROVED
Reason: APPROVE, PENDING ELIGIBILITY

Approved service type: MEDICAL CARE
Approved procedure range:
Beginning procedure: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE
Ending procedure: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHY
Quantity: 11 UNITS
Frequency: AS NEEDED

Servicing provider: SLUCARE PEDIATRICS ENDOCRINOLO
Specialty: MIXED SPECIALTY CLINIC
Phone: 314-577-5648

Associated group: SLUCARE PEDIATRICS ENDOCRINOLO
Address: 1465 S GRAND BLVD SAINT LOUIS, MO 63104
Phone: 314-577-5648
Fax: 314-268-6448

Referring provider: SCOTT AFB MEDICAL CLINIC-375TH
Specialty: OTHER
Address: 310 W LOSEY ST SCOTT AIR FORCE BASE, IL 6222
Phone: 618-256-9355
Fax: 618-744-9692

AskUs a question.

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## Authorizations and Referrals

Health Net Federal Services

Authorization number: [redacted] View claims for this authorization

Patient: [redacted]
DoD Benefits Number: [redacted]
Patient date of birth: [redacted]
Primary diagnosis:
Secondary diagnosis:
Plan: TRICARE PRIME FAMILY COVERAGE FOR ACTIVE DUTY
Sponsor: [redacted]
Sponsor SSN: [redacted]

Begin date of service: 10-28-2014
End date of service: 01-26-2015
Place of service: OUTPATIENT HOSPITAL
Decision: APPROVED
Reason: APPROVE, PENDING ELIGIBILITY

Approved service type: MEDICAL CARE
Approved procedure range:
Beginning procedure: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATIION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFI
Ending procedure: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIE
Quantity: 1 UNITS
Frequency: AS NEEDED

Servicing provider: SLUCARE PEDIATRICS ENDOCRINOLO
Specialty: MIXED SPECIALTY CLINIC
Phone: 314-577-5648

Associated group: SLUCARE PEDIATRICS ENDOCRINOLO
Address: 1465 S GRAND BLVD SAINT LOUIS, MO 63104
Phone: 314-577-5648
Fax: 314-268-6448

Referring provider: SCOTT AFB MEDICAL CLINIC-375TH
Specialty: OTHER
Address: 310 W LOSEY ST SCOTT AIR FORCE BASE, IL 6222
Phone: 618-256-9355
Fax: 618-744-9692

AskUs a question.

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# EXHIBIT B

[redacted]

Health Net® FEDERAL SERVICES | TRICARE®

Date: October 13, 2015

Check prior authorization and referral status online!
Visit
[redacted]/auth/status

[redacted]

[redacted]

Sponsor Name: [redacted]
Patient ID: [redacted]
Beneficiary Plan Type: TRICARE Prime
Beneficiary Date of Birth: [redacted]
Beneficiary Phone Number: [redacted]

**Referred To Provider:**
DAVID DEMPSHER, MD
[redacted]

Health Net Federal Services, LLC (Health Net) received a request from your provider for health care services. This request has been denied for coverage under the TRICARE® program.

Reference Number: [redacted]
Provider Specialty: Pediatric Endocrinology

Diagnosis 1: F64.2 Gender identity disorder of childhood

| Service Codes | Service Dates | Visits/Units |
|---|---|---|
| 99201* - 99205 | 10/13/2015 - 01/11/2016 | 1 |
| 99211* - 99215 | 10/13/2015 - 10/12/2016 | 11 |

* (99201) Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

* (99211) Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.







[redacted]

[redacted]

Requesting Military Treatment Facility (MTF): SCOTT AFB MEDICAL CLINIC-375TH MED GRP
Requesting MTF Phone Number: [redacted]
Requesting MTF NPI: [redacted] Requesting MTF NPI Type Code: 2
Individual Requesting Provider: CHAUNCEY TARRANT
Individual Requesting Provider NPI: [redacted] Individual Requesting Provider Type Code: 1

The decision to deny this request is based on the following reason:

Chapter 7, Section 1.1 of the TRICARE Policy Manual (TPM) excludes cost share for services and supplies provided in connection with psychotherapy for sexual dysfunction, paraphilias, and gender identity disorders. This includes therapy that is wholly or partially related to treating the sexual dysfunction, paraphilias (e.g. transvestite fetishism) or gender identity disorder, such as sex therapy, sexual counseling, sex behavior modification, psychotherapy, or other similar services.

When a service is found to be non-covered, help may be available from alternative resources. One of the most important sources is the provider who requested the service, as there may be a reasonable alternative medical treatment. When there are no specific medical alternatives for the non-covered service you may want to consider contacting local and national agencies that offer help for people with specific medical problems. Health Net has comprised a list of the most frequently requested non-covered services and possible resources for getting help in obtaining the service outside of your medical coverage. For more information visit the "Resources" page on our web site at the following address:

**www.hnfs.com**

Your appeal rights as a TRICARE beneficiary are outlined in the attachment "YOUR APPEAL RIGHTS." The information will explain what to do should you, your physician or the facility disagree with the denial decision.

If you have any questions regarding this notice, please feel free to contact us at the following toll-free number:

**Toll Free Telephone Number: 877-TRICARE (874-2273)**

Sincerely,

CHARLIE SAELEE
Intake Rep I

cc: SCOTT AFB MEDICAL CLINIC-375TH MED GRP

[redacted]

Health Net® FEDERAL SERVICES | TRICARE®

## YOUR APPEAL RIGHTS

An appropriate appealing party who is dissatisfied with the initial denial determination relative to the services addressed in this letter, has the right to ask for a reconsideration of the denied services/procedure(s). According to TRICARE® guidelines, an appropriate appealing party is:

- The TRICARE beneficiary (including minors)
- The non-network participating provider of care
- The appointed representative of an appropriate appealing party

** Please note:*

- A custodial parent of a minor beneficiary is considered the "appointed representative" of the minor beneficiary until the beneficiary reaches 18 years of age (21 years of age for residents of Pennsylvania), at which time he/she must submit the appeal in their own behalf or appoint a representative (i.e., parent) in writing.
- A *"network"* provider is not an appropriate appealing party, however the *"network"* provider *may* be appointed by an appropriate appealing party to represent them in the TRICARE appeal.
- A Military Treatment Facility (MTF) provider or other employee of the United States Government is not a proper appealing party and, due to conflict of interest, *may not* be appointed as representative. An exception to this is made for an employee or member of a Uniformed Service who represents an immediate family member.

The following guidelines apply when requesting a reconsideration:

- The request must be in writing
- The request must be signed
- The request must include a copy of this determination letter
- **The request must be postmarked or received by the filing deadline outlined below in the instructions for requesting a "non-expedited reconsideration." For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service.**

The following guidelines apply to submitting or requesting *"additional documentation:"*

- Additional documentation in support of the appeal may be submitted. However, because a request for reconsideration must be postmarked or received within the timeframes outlined below, a request for reconsideration should not be delayed pending the acquisition of additional documentation. **You have the right to obtain copies of documents and information upon which our initial denial determination was made, however photocopying of requested documents and information could result in a reasonable charge for photocopies and first class postage.*

- If additional information is to be submitted at a later date, or if you would like additional time to review any requested documentation related to our initial denial, the letter requesting reconsideration must indicate this.

- **Unless your request for reconsideration indicates that there will be a delay due to reviewing additional documentation or submitting additional information, we will begin our reconsideration review/evaluation upon receipt of your request.**

**Please be aware:*

- If you decide to proceed with the denied service(s) addressed in this letter and the service(s) are provided by a *"network"* provider, you may be *"held harmless."* If you need assistance to determine if the provider is *"network"* you may contact us at 877-TRICARE (874-2273).

[redacted]

- A *"network"* provider cannot bill the beneficiary for non-covered care unless the following occurred:
  - You were notified that the services were not covered or, were not likely to be covered, by TRICARE and agreed in advance to pay for the services. An agreement to pay must be evidenced by written records. General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or excludable.
  - The beneficiary did not inform the provider that he/she was a TRICARE beneficiary.

- Under "hold harmless", you have no financial liability and therefore have no further appeal rights. However, if "hold harmless" does not apply as outlined above, you will be financially liable and the appeal instructions below apply.

**FILING YOUR APPEAL (RECONSIDERATION)**

**There are multiple types of appeals available under the TRICARE appeal process. However, only "non-expedited" appeal rights apply to benefit/factual denials.**

Instructions for filing your "non-expedited" reconsideration:
- The beneficiary, the appointed representative of the beneficiary or the "non-network" participating provider, must file the "non-expedited" reconsideration request. (See guidelines above).
- The request must be filed within ninety (90) calendar days from the date of this denial determination. (The denial determination letter should be included with the request).
- Once your request for reconsideration is received, all your TRICARE claims or relevant authorization requests for the entire course of treatment will be reviewed.
- Our reconsideration determination letter will be mailed to the appealing party within thirty (30) calendar days, not to exceed sixty (60) calendar days after the "non-expedited" appeal request is received.

Mail "non-expedited" reconsideration requests to:

Health Net -- TRICARE North
Authorization Appeals
P.O. Box 9530
Virginia Beach, VA 23450-9530

If you prefer, you may submit your request via:
- The confidential fax number: 888-881-3622.
- Health Net Federal Services secure website: **www.hnfs.com**. The Appeal page can be found under the Resources menu.

*Additional documentation in support of the web appeal can be faxed to: 888-881-3622 indicating "Additional Appeal Documentation" on fax cover.*

[redacted]

# EXHIBIT C

# TRICARE North - Health Net Appeals Form

Here is a preview of what will be submitted to Health Net. You will be able to print the form and obtain a tracking number after submission.

**Submitter Information**

Relationship to Patient/Beneficiary: Parent

You may appeal on behalf of a dependent child under age 18 (under age 21 for Pennsylvania residents). A parent of an adult dependent is not an appropriate appealing party unless legal documents such as Power of Attorney are on file with Health Net. However, the patient/beneficiary may complete and submit the Appointment of Representative form to appoint you as their representative.

Name - Last, First MI.: [redacted]
Street Address: [redacted]
City, State, ZIP Code: [redacted]
Daytime Phone#: [redacted]
Daytime Fax Number: [redacted]
Email Address: [redacted]

**Sponsor Information**

Name - Last, First: [redacted]
SSN: [redacted]

**Patient/Beneficiary Information**

Name - Last, First MI.: [redacted]
Date of Birth: [redacted]
Street Address: [redacted]
City, State, ZIP Code: [redacted]

**Rendering Provider / Facility Information**

Group/Facility Name: Cardinal Glennon
Individual Provider Name: David Dempsher
Street Address: [redacted]
City, State, ZIP Code:
Daytime Phone:
Fax Number:
Tax ID Number (TIN):

**Claim or Authorization Denial Information**

Have the Services Occurred?: No

If you have more than 2 authorization/ reference, enter additional numbers below in the "Issue in Dispute" section.

Authorization/Reference Number (s): [redacted]

CPT, HCPC or description of Service or Procedure Denied: Pediatric Endocrinology

Appeals must be submitted within 90 days from the date of denial. Please be sure to include the reason for the delayed appeal if this date is more than 90 days ago.

Date of Denied Claim or Authorization: 10/13/2015

**Issue in Dispute**

Please state the specific reason for your appeal. Try to be brief, but be sure to include the rationale for your request or the reason you believe the service should be covered.

I am appealing this denial on two counts: (1) that the endocrine care requested is a medically necessary, safe, and effective treatment for Gender Identity Disorder, and (2) that continuing to deny this medically necessary care constitutes unlawful discrimination based on gender identity.

Since the endocrine care requested is covered for non-transgender people for other medical conditions, the denial of coverage for this procedure constitutes discrimination based on gender identity. According to the Illinois Department of Insurance Company Bulletin 2014-10, this denial of coverage violates Section 1-102 of the Illinois Human Rights Act and Section 1557 of the Patient Protection and Affordable Care Act of 2010, the latter of which applies to all health programs and activities of which any part receives federal financial assistance, including TriCare health plans.

You may send additional supporting documentation to Health Net Federal Services Appeals Department via fax at 1-888-881-3622 or by mail to:

Health Net Federal Services
Appeals Auth
P.O. Box 870142
Surfside Beach, SC 29587-9742

[redacted]

11/2/2015

Please check this box if you intend to submit additional documentation via fax or mail.

**Additional Documents:** No

# EXHIBIT D

Health Net®
FEDERAL SERVICES

TRICARE®

[redacted]

11/23/2015

[redacted]

Beneficiary: [redacted]
Eligibility Status: [redacted]
Sponsor Name: [redacted]
Sponsor SSN: [redacted]

Appeal Type: Prospective
Inital Denial Type: Factual (not a benefit)
Dates of Service: N/A -
Authorization: [redacted]

**Care in Dispute:** Office Visits

**Providers Involved in Episode of Care:**

| Name | Status |
|---|---|
| Slucare Univeristy DBA Slucare, David Dempsher MD | Network |

Health Net Federal Services, LLC (Health Net) is the Managed Care Support contractor authorized by the TRICARE program to review health care services provided to TRICARE eligible beneficiaries residing in the North Region. Health Net has completed your appeal after thorough review of the care in dispute, applicable TRICARE regulations, additional information presented, and the opinion of the medical reviewers.

**Appeal Determination Summary**

Based upon TRICARE policy and the opinion expressed by the second reviewer, the initial denial is upheld as not a TRICARE benefit. Detailed rationale is provided in the Discussion section below.

[redacted]

## STATEMENT OF ISSUE

The following service(s) are under review: Office Visits. Authorization was requested for this care, and the initial reviewer denied the request as not a TRICARE benefit.

In addition to your appeal, there were concerns of TRICARE benefits.

## APPLICABLE AUTHORITY

TRICARE benefits are authorized by Congressional legislation incorporated in Chapter 55 of Title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in Title 32, Code of Federal Regulations, Part 199 (32 CFR 199). Specific regulation provisions pertinent to this case are set forth below. Also see additional applicable authorities enclosed.

TRICARE Policy Manual Chapter 1 Section 1.2 Exclusions
Authority:32 CFR 199.4(g)

1.0 POLICY
1.1 In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of the TRICARE Policy Manuals, the following specifically are excluded:

1.1.29 Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in 32 CFR 199.4(e)(7) (see Chapter 4, Sections 15.1, 16.1, 17.1, and Chapter 7, Section 1.1).

---

32 CFR 199.4(g)(29) Exclusions and limitations
Transsexualism or such other conditions as gender dysphoria.
Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in paragraph (e)(7) of this section.

32 CFR 199.4(e)(7)
Transsexualism or such other conditions as gender dysphoria.
All services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under CHAMPUS. This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender dysphoria. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, CHAMPUS benefits may be extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.

TRICARE Policy Manual Chapter 7, Section 1.1 Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders
Authority:32 CFR 199.4(g)(30) and Title 10, United States Code (USC) 1079(a)(10)

2.0 POLICY
Diagnostic studies necessary to establish organic versus psychogenic disorders, and appropriate medical and surgical treatment related to sexual dysfunctions including sexual disinhibition with an organic origin (e.g., disease, trauma, injury, or radical surgery) may be cost-shared under the TRICARE Program.

3.0 EXCLUSIONS
3.1 Non-medical (psychiatric) services are not a benefit for organic sexual dysfunction.
3.2 Services and supplies provided in connection with psychotherapy for sexual dysfunctions, Paraphilias, and gender identify disorders are specifically excluded from cost-sharing. This includes therapy that is wholly or partially related to treating the sexual dysfunctions, paraphilias (e.g., transvestic fetishism) or gender identity disorder, such as sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy, or other similar services.

[redacted]

**DISCUSSION**

A request for reconsideration was received by Health Net and was presented to a second reviewer.

Materials Reviewed

The following were included in the review: the appeal request, any additional documentation submitted with your request, other supporting documentation, and the original denial information.

Initial Reviewer's Comments

The initial reviewer determined that the care in dispute was not a TRICARE benefit. The initial reviewer's comments were:

> Chapter 7, Section 1.1 of the TRICARE Policy Manual (TPM) excludes cost share for services and supplies provided in connection with psychotherapy for sexual dysfunction, paraphilias, and gender identity disorders. This includes therapy that is wholly or partially related to treating the sexual dysfunction, paraphilias (e.g. transvestite fetishism) or gender identity disorder, such as sex therapy, sexual counseling, sex behavior modification, psychotherapy, or other similar services.

Relevant Medical History

This is a 9-year-old male patient diagnosis of Gender Identity Disorder of Childhood [ICD10: F64.2]. The patient is stated to have consistent transgender (natal female-to-male) identity without dysphoria.

Second reviewer's comments:

> The parent of the beneficiary is appealing the denial of Office Consult and Visits [CPT: 99201-99205 and 99211-99215] for Gender Identity Disorder of Childhood [ICD10: F64.2]. An authorization for service had been requested with the visits being denied on authorization number 0055-151006-01214 (Reference 3075091).
>
> TRICARE Policy Manual (TPM) Chapter 7 Section 1.1 pertains to Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders. This policy states that diagnostic studies necessary to establish organic versus psychogenic disorders, and appropriate medical and surgical treatment related to sexual dysfunctions including sexual disinhibition with an organic origin (e.g., disease, trauma, injury, or radical surgery) may be cost-shared under the TRICARE Program. However, services and supplies provided in connection with psychotherapy for sexual dysfunctions, Paraphilias, and gender identify disorders are specifically excluded from cost-sharing. This includes therapy that is wholly or partially related to treating the sexual dysfunctions, paraphilias (e.g., transvestic fetishism) or gender identity disorder, such as sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy, or other similar services.
>
> TPM Chapter 1 Section 1.2 excludes services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in 32 CFR 199.4(e)(7) (see Chapter 4, Sections 15.1, 16.1, 17.1, and Chapter 7, Section 1.1).
>
> The initial denial is upheld.

While we have determined that the services cannot be covered under TRICARE benefits, we found that there were concerns about the benefits and "unlawful discrimination" due to benefit denial(s). Our Grievance department is reviewing the circumstances. You will receive a separate response from the Grievance department with their findings and corrective actions if appropriate. However, if you have further TRICARE appeal rights detailed in this letter and wish to appeal to the next level, you should follow the appeal instructions and file within the listed time frame.

**DECISION:**

Based upon TRICARE policy and the opinion expressed by the second reviewer, the initial denial is upheld as not a TRICARE benefit.

[redacted]

Amount In Dispute

In accordance with 32 CFR. 199.10, there must be an amount in dispute for TRICARE to process a formal appeal. The amount in dispute is an esimate of the amount of money TRICARE would pay if the denied services and supplies were determined to be TRICARE benefits. The amount in dispute is the estimated allowed amount or the cost for the requested service. Related services (i.e. anesthesia and facility fees for a surgery) are not included in the amount in dispute for authorization denials as we cannot provide an accurate estimate of related charges.

The amount remaining in dispute after this reconsideration review is estimated to be $257.92

## APPEAL RIGHTS

An administrative reconsideration review is available under the TRICARE appeal process when a denial is based on a requirement of law or regulation. However, because disputes challenging a requirement of law or regulation do not present an appealable issue, they are ineligible for appeal to a formal review or hearing. Since the disputed care in this case is excluded by law or regulation, further appeal is not authorized. This reconsideration determination completes the administrative appeal process under 32 CFR 199.10, and no further administrative appeal is available.

Although disputes challenging a requirement of law or regulation are not appealable to a formal review or hearing, further appeal to a formal review or hearing is available to dispute whether the law or regulation was properly applied if other requirements are satisfied, such as the requisite amount in dispute. For example, services and supplies related to treating obesity are excluded by law and regulation when obesity is the only or the major condition being treated. If a service or supply was provided to treat hypertension, but the obesity exclusion was erroneously applied, an appeal may be filed to challenge the erroneous application of the obesity exclusion. As a further example, if law or regulation excludes durable medical equipment, but the actual service provided was for a prosthetic device, an appeal may be filed on the grounds that the durable medical equipment exclusion was incorrectly applied to the prosthetic device coverage determination.

To dispute whether the law or regulation was properly applied a request for formal review must be postmarked or received by DHA within 60 days from the date of this notice.

Send your request for a formal review to:

Defense Health Agency (DHA)
Appeals and Hearings Division
16401 East Centretech Parkway
Aurora, CO 80011-9043

Services by Network Providers:
If any portion of the denied services is provided by a network provider, the beneficiary may be 'held harmless' from financial liability despite the service having been determined to be non-covered by TRICARE. A network provider cannot bill the beneficiary for non-covered care unless the beneficiary was informed in advance that the care was not covered by TRICARE, and waived their right to hold harmless by agreeing in advance, in writing to pay for the specific non-covered care. Under hold harmless, the beneficiary has no financial liability and therefore has no further appeal rights. However, If the beneficiary agreed in advance to waive their rights to hold harmless, the beneficiary would be financially liable and the appeal rights outlined above would apply.

[redacted]

If you have any questions regarding this notice or have questions about TRICARE benefits or eligibility, please contact Health Net at the following toll-free number and one of our associates will be happy to assist you.

Telephone Number: 1-877-TRICARE (1-877-874-2273)

Sincerely,

Kang Vang
TRICARE North Appeals

CC:

[redacted]

## ADDITIONAL APPLICABLE AUTHORITY REFERENCES:

TRICARE benefits are authorized by Congressional legislation incorporated in Chapter 55 of Title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in Title 32, Code of Federal Regulations, Part 199 (32 CFR 199). Specific regulation provisions pertinent to this case are set forth below.

32 CFR 199.4(a)(1)(i) Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this part, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

32 CFR 199.2(b) Defines appropriate medical care in pertinent part as that medical care where the services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care are in keeping with the generally accepted norms for medical practice in the United States and where the authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards. The definition also specifies that the medical environment in which the medical services are performed is at the level adequate to provide the required medical care.

32 CFR 199.2(b) Defines medically or psychologically necessary in pertinent part as the frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

32 CFR 199.4(a)(5) Right to information. As a condition precedent to the provision of benefits, OCHAMPUS or its OCHAMPUS (contractors)...shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval of benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for pre-authorization or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determination, when necessary, which information will, subject to certain specific exclusions, be held confidential by the recipient.

32 CFR 199.4(g)(63) Non-covered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized provider are specifically excluded from the Basic Program.

32 CFR 199.10(a)(3) Burden of proof. The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this part to the authorization of CHAMPUS benefits, approval of authorized CHAMPUS provider status, or removal of sanctions imposed under Sec. 199.9 of this part. If a presumption exists under the provisions of this part or information constitutes prima facie evidence under the provisions of this part, the appealing party must produce evidence reasonably sufficient to rebut the presumption or prima facie evidence as part of the appealing party's burden of proof. CHAMPUS shall not pay any part of the cost or fee, including attorney fees, associated with producing or submitting evidence in support of an appeal.

32 CFR 199.4(g) Exclusions and limitations. In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this part, the following specifically are excluded from the Basic Program: (1) Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy or well-baby care.

32 CFR 199.4(g) Exclusions and limitations. Note: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

32 CFR 199.4(a)(13) Implementing instructions. The Director, OCHAMPUS, shall issue policies, procedures, instructions, guidelines, standards and/or criteria to implement 32 CFR 199.4.

TRICARE Operations Manual Chapter 12 Section 2 Governing Principals - Erroneous Payments

[redacted]

In considering an issue under appeal, questions may arise concerning previous payment of services or claims not under appeal. Possible erroneous payments will be reviewed in depth, including medical review if necessary, to determine if, at the time the initial determination was made, there existed any basis for the payment. If the reviewer concludes there was a basis for payment at the time the claim was processed, the payment may stand. When the evidence indicates a payment was erroneous and not supported by law or regulation, the following action will be taken.

Recoupment Involving Issues Under Appeal - When the contractor examines claims which are related to the claim in dispute and determines that one or more of the related claims were improperly paid, the contractor shall explain the erroneous payment in detail and advise the appealing party of any recoupment. If the contractor determines recoupment is appropriate, the amount of the erroneously paid claim(s) will be added to the amount in dispute, and the reconsideration review will consider both the claim(s) in dispute and the erroneously paid related claim(s) which involve the same issue. If the total amount in dispute permits a higher level appeal, the appealing party will be so advised.

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TRICARE Operations Manual Chapter 12, Section 2 Governing Principals - Related Claims
When the contractor receives an appeal on a claim which has been denied, the contractor shall retrieve and examine all claims related to the specific service or supply or EOC received by the beneficiary to determine if the claim in dispute was properly denied and if related claims were properly processed. All claims which relate to the same incident of care or the same type of service to the beneficiary shall be processed in the same manner and shall be readjudicated and resolved along with the denied claim in the same reconsideration determination. If one claim which relates to an excluded procedure is denied, all claims which relate to the same procedure shall also be denied. If a procedure is covered and one claim involving that procedure and EOC is paid, other claims relating to the same procedure and/or period of care which have been denied should be examined in conjunction with the paid claim to see if the other claims may be paid or whether all the claims should be uniformly denied. The contractor shall take action in accordance with paragraph 4.4.2 to determine if any claim for the services or supplies was improperly paid or denied. All related claims shall be made part of the appeal file. The file shall contain full documentation pertaining to the issue and the care in dispute, to include a record of actions taken by the contractor on all claims involving the same issue.

# EXHIBIT E

Health Net Federal Services

TRICARE

November 25, 2015

[redacted]

Beneficiary Name: [redacted]
Case #: [redacted]
Date Received: 11/2/2015

Dear [redacted]

Health Net Federal Services, Inc. (Health Net) is the Managed Care Support Contractor (MCSC) for the TRICARE Program in the North Region. The Health Net Grievance Department is still in the process of obtaining the information needed to complete the review of your concerns. We anticipate final review will occur within 60 days from the original receipt of your grievance. After completion of this review, you will receive a written response.

Communication regarding grievances must be in writing; however, if you need help with other TRICARE issues you may call 1-877-TRICARE (1-877-874-2273). If you have additional information to add to your grievance you may use the following address, fax number or online grievance form.

Health Net Federal Services, LLC
Attn: TRICARE North Grievances
P.O. Box 2399
Virginia Beach, VA 23450-2399
Fax Number: 1-888-317-6155
Online: www.hnfs.com (Grievance page is under the Resources tab)

Sincerely,

Ron Haven
TRICARE North Grievance Department

# EXHIBIT F

Health Net®
FEDERAL SERVICES

TRICARE®

December 22, 2015

[redacted]

**Beneficiary:** [redacted]
**Case #:** [redacted]

Dear [redacted]

Health Net Federal Services (Health Net) has completed review of the grievance included in your appeal received on 11/02/15 for reconsideration of denied services. In your appeal, you expressed concern that the denial of coverage for your dependent's endocrinology care services constitutes discrimination based on gender identity.

The grievance process allows us to thoroughly review and address your concerns, and take the necessary steps to help prevent any quality issues from reoccurring. The appeal for reconsideration of the denial was conducted separately and a copy of the determination is enclosed with this correspondence for your reference. We noted from our appeals records that the decision was to uphold the initial denial. Please refer to the letter dated 11/25/15 from our appeals department for a formal and detailed explanation of their decision.

We sincerely regret this decision could not have been more favorable. However, we are required to provide benefit coverage in accordance with our contract under the Department of Defense (DoD) and ensure TRICARE policy is met for all beneficiaries.

**TRICARE and State Laws**
TRICARE benefits are authorized by Congressional legislation incorporated in Chapter 55 of Title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in Title 32, Code of Federal Regulations, Part 199 (32 CFR 199). Although there may be situations in which federal law is in conflict with the law in the state(s) in which a contractor may be based or operating, federal law as applicable to the Department of Defense (DoD) has precedence over the state law, except as it pertains to the health privacy rights of minors.

**Further Appeal Rights**
Health Net Federal Services (HNFS) does not have the authority to allow services that have been explicitly excluded by TRICARE policy and must comply with all federal laws which apply to the administration of the TRICARE health plan. However, our records indicate that you were informed that you have further appeal rights with the Defense Health Agency (DHA) for additional review of the denial of the endocrine services for Gender Identity Disorder treatment. As such, you are encouraged to exhaust all available levels of appeal.

[redacted]

We appreciate you bringing this matter to our attention. If you have any additional concerns or wish to request further review, please notify us in writing at the address listed below. Please include all information or documentation you feel is pertinent to an additional review.

Health Net Federal Services, LLC
ATTN: TRICARE North Grievances
P.O. Box 2399
Virginia Beach, VA 23450-2399
Fax Number: 1-888-317-6155

Our Customer Service Representatives are available to answer any questions or concerns you may have. Please feel free to contact customer service by calling 1-877-TRICARE (1-877-874-2273) or visit us online at www.hnfs.com.

Respectfully,

Ronald Haven
Grievance Specialist
TRICARE North Grievance Department

Enclosure: As listed above

Health Net FEDERAL SERVICES

TRICARE

[redacted]

11/23/2015

[redacted]

| | | | |
|---|---|---|---|
| Beneficiary: | [redacted] | Appeal Type: | Prospective |
| Eligibility Status: | ADFM Prime | Inital Denial Type: | Factual (not a benefit) |
| Sponsor Name: | [redacted] | Dates of Service: | N/A - |
| Sponsor SSN: | [redacted] | Authorization: | [redacted] |

**Care in Dispute:** Office Visits

**Providers Involved in Episode of Care:**

| Name | Status |
|---|---|
| Slucare Univeristy DBA Slucare, David Dempsher MD | Network |

Health Net Federal Services, LLC (Health Net) is the Managed Care Support contractor authorized by the TRICARE program to review health care services provided to TRICARE eligible beneficiaries residing in the North Region. Health Net has completed your appeal after thorough review of the care in dispute, applicable TRICARE regulations, additional information presented, and the opinion of the medical reviewers.

**Appeal Determination Summary**

Based upon TRICARE policy and the opinion expressed by the second reviewer, the initial denial is upheld as not a TRICARE benefit. Detailed rationale is provided in the Discussion section below.

[redacted]

## STATEMENT OF ISSUE

The following service(s) are under review: Office Visits. Authorization was requested for this care, and the initial reviewer denied the request as not a TRICARE benefit.

In addition to your appeal, there were concerns of TRICARE benefits.

## APPLICABLE AUTHORITY

TRICARE benefits are authorized by Congressional legislation incorporated in Chapter 55 of Title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in Title 32, Code of Federal Regulations, Part 199 (32 CFR 199). Specific regulation provisions pertinent to this case are set forth below. Also see additional applicable authorities enclosed.

TRICARE Policy Manual Chapter 1 Section 1.2 Exclusions
Authority:32 CFR 199.4(g)

1.0 POLICY
1.1 In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of the TRICARE Policy Manuals, the following specifically are excluded:

1.1.29 Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in 32 CFR 199.4(e)(7) (see Chapter 4, Sections 15.1, 16.1, 17.1, and Chapter 7, Section 1.1).

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32 CFR 199.4(g)(29) Exclusions and limitations
Transsexualism or such other conditions as gender dysphoria.
Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in paragraph (e)(7) of this section.

32 CFR 199.4(e)(7)
Transsexualism or such other conditions as gender dysphoria.
All services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under CHAMPUS. This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender dysphoria. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, CHAMPUS benefits may be extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.

TRICARE Policy Manual Chapter 7, Section 1.1 Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders
Authority:32 CFR 199.4(g)(30) and Title 10, United States Code (USC) 1079(a)(10)

2.0 POLICY
Diagnostic studies necessary to establish organic versus psychogenic disorders, and appropriate medical and surgical treatment related to sexual dysfunctions including sexual disinhibition with an organic origin (e.g., disease, trauma, injury, or radical surgery) may be cost-shared under the TRICARE Program.

3.0 EXCLUSIONS
3.1 Non-medical (psychiatric) services are not a benefit for organic sexual dysfunction.
3.2 Services and supplies provided in connection with psychotherapy for sexual dysfunctions, Paraphilias, and gender identify disorders are specifically excluded from cost-sharing. This includes therapy that is wholly or partially related to treating the sexual dysfunctions, paraphilias (e.g., transvestic fetishism) or gender identity disorder, such as sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy, or other similar services.

[redacted]

**DISCUSSION**

A request for reconsideration was received by Health Net and was presented to a second reviewer.

Materials Reviewed

The following were included in the review: the appeal request, any additional documentation submitted with your request, other supporting documentation, and the original denial information.

Initial Reviewer's Comments

The initial reviewer determined that the care in dispute was not a TRICARE benefit. The initial reviewer's comments were:

> Chapter 7, Section 1.1 of the TRICARE Policy Manual (TPM) excludes cost share for services and supplies provided in connection with psychotherapy for sexual dysfunction, paraphilias, and gender identity disorders. This includes therapy that is wholly or partially related to treating the sexual dysfunction, paraphilias (e.g. transvestite fetishism) or gender identity disorder, such as sex therapy, sexual counseling, sex behavior modification, psychotherapy, or other similar services.

Relevant Medical History

This is a 9-year-old male patient diagnosis of Gender Identity Disorder of Childhood [ICD10: F64.2]. The patient is stated to have consistent transgender (natal female-to-male) identity without dysphoria.

Second reviewer's comments:

> The parent of the beneficiary is appealing the denial of Office Consult and Visits [redacted] for Gender Identity Disorder of Childhood [ICD10: F64.2]. An authorization for service had been requested with the visits being denied on authorization number [redacted]
>
> TRICARE Policy Manual (TPM) Chapter 7 Section 1.1 pertains to Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders. This policy states that diagnostic studies necessary to establish organic versus psychogenic disorders, and appropriate medical and surgical treatment related to sexual dysfunctions including sexual disinhibition with an organic origin (e.g., disease, trauma, injury, or radical surgery) may be cost-shared under the TRICARE Program. However, services and supplies provided in connection with psychotherapy for sexual dysfunctions, Paraphilias, and gender identify disorders are specifically excluded from cost-sharing. This includes therapy that is wholly or partially related to treating the sexual dysfunctions, paraphilias (e.g., transvestic fetishism) or gender identity disorder, such as sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy, or other similar services.
>
> TPM Chapter 1 Section 1.2 excludes services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in 32 CFR 199.4(e)(7) (see Chapter 4, Sections 15.1, 16.1, 17.1, and Chapter 7, Section 1.1).
>
> The initial denial is upheld.

While we have determined that the services cannot be covered under TRICARE benefits, we found that there were concerns about the benefits and "unlawful discrimination" due to benefit denial(s). Our Grievance department is reviewing the circumstances. You will receive a separate response from the Grievance department with their findings and corrective actions if appropriate. However, if you have further TRICARE appeal rights detailed in this letter and wish to appeal to the next level, you should follow the appeal instructions and file within the listed time frame.

**DECISION:**

Based upon TRICARE policy and the opinion expressed by the second reviewer, the initial denial is upheld as not a TRICARE benefit.

[redacted]

Amount In Dispute

In accordance with 32 CFR. 199.10, there must be an amount in dispute for TRICARE to process a formal appeal. The amount in dispute is an esimate of the amount of money TRICARE would pay if the denied services and supplies were determined to be TRICARE benefits. The amount in dispute is the estimated allowed amount or the cost for the requested service. Related services (i.e. anesthesia and facility fees for a surgery) are not included in the amount in dispute for authorization denials as we cannot provide an accurate estimate of related charges.

The amount remaining in dispute after this reconsideration review is estimated to be $257.92

**APPEAL RIGHTS**

An administrative reconsideration review is available under the TRICARE appeal process when a denial is based on a requirement of law or regulation. However, because disputes challenging a requirement of law or regulation do not present an appealable issue, they are ineligible for appeal to a formal review or hearing. Since the disputed care in this case is excluded by law or regulation, further appeal is not authorized. This reconsideration determination completes the administrative appeal process under 32 CFR 199.10, and no further administrative appeal is available.

Although disputes challenging a requirement of law or regulation are not appealable to a formal review or hearing, further appeal to a formal review or hearing is available to dispute whether the law or regulation was properly applied if other requirements are satisfied, such as the requisite amount in dispute. For example, services and supplies related to treating obesity are excluded by law and regulation when obesity is the only or the major condition being treated. If a service or supply was provided to treat hypertension, but the obesity exclusion was erroneously applied, an appeal may be filed to challenge the erroneous application of the obesity exclusion. As a further example, if law or regulation excludes durable medical equipment, but the actual service provided was for a prosthetic device, an appeal may be filed on the grounds that the durable medical equipment exclusion was incorrectly applied to the prosthetic device coverage determination.

To dispute whether the law or regulation was properly applied a request for formal review must be postmarked or received by DHA within 60 days from the date of this notice.

Send your request for a formal review to:

Defense Health Agency (DHA)
Appeals and Hearings Division
16401 East Centretech Parkway
Aurora, CO 80011-9043

Services by Network Providers:
If any portion of the denied services is provided by a network provider, the beneficiary may be 'held harmless' from financial liability despite the service having been determined to be non-covered by TRICARE. A network provider cannot bill the beneficiary for non-covered care unless the beneficiary was informed in advance that the care was not covered by TRICARE, and waived their right to hold harmless by agreeing in advance, in writing to pay for the specific non-covered care. Under hold harmless, the beneficiary has no financial liability and therefore has no further appeal rights. However, If the beneficiary agreed in advance to waive their rights to hold harmless, the beneficiary would be financially liable and the appeal rights outlined above would apply.

[redacted]

If you have any questions regarding this notice or have questions about TRICARE benefits or eligibility, please contact Health Net at the following toll-free number and one of our associates will be happy to assist you.

Telephone Number: 1-877-TRICARE (1-877-874-2273)

Sincerely,

Kang Vang
TRICARE North Appeals

CC:

[redacted]

## ADDITIONAL APPLICABLE AUTHORITY REFERENCES:

TRICARE benefits are authorized by Congressional legislation incorporated in Chapter 55 of Title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in Title 32, Code of Federal Regulations, Part 199 (32 CFR 199). Specific regulation provisions pertinent to this case are set forth below.

32 CFR 199.4(a)(1)(i) Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this part, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

32 CFR 199.2(b) Defines appropriate medical care in pertinent part as that medical care where the services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care are in keeping with the generally accepted norms for medical practice in the United States and where the authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards. The definition also specifies that the medical environment in which the medical services are performed is at the level adequate to provide the required medical care.

32 CFR 199.2(b) Defines medically or psychologically necessary in pertinent part as the frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

32 CFR 199.4(a)(5) Right to information. As a condition precedent to the provision of benefits, OCHAMPUS or its OCHAMPUS (contractors)...shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval of benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for pre-authorization or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determination, when necessary, which information will, subject to certain specific exclusions, be held confidential by the recipient.

32 CFR 199.4(g)(63) Non-covered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized provider are specifically excluded from the Basic Program.

32 CFR 199.10(a)(3) Burden of proof. The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this part to the authorization of CHAMPUS benefits, approval of authorized CHAMPUS provider status, or removal of sanctions imposed under Sec. 199.9 of this part. If a presumption exists under the provisions of this part or information constitutes prima facie evidence under the provisions of this part, the appealing party must produce evidence reasonably sufficient to rebut the presumption or prima facie evidence as part of the appealing party's burden of proof. CHAMPUS shall not pay any part of the cost or fee, including attorney fees, associated with producing or submitting evidence in support of an appeal.

32 CFR 199.4(g) Exclusions and limitations. In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this part, the following specifically are excluded from the Basic Program: (1) Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy or well-baby care.

32 CFR 199.4(g) Exclusions and limitations. Note: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

32 CFR 199.4(a)(13) Implementing instructions. The Director, OCHAMPUS, shall issue policies, procedures, instructions, guidelines, standards and/or criteria to implement 32 CFR 199.4.

TRICARE Operations Manual Chapter 12 Section 2 Governing Principals - Erroneous Payments

[redacted]

In considering an issue under appeal, questions may arise concerning previous payment of services or claims not under appeal. Possible erroneous payments will be reviewed in depth, including medical review if necessary, to determine if, at the time the initial determination was made, there existed any basis for the payment. If the reviewer concludes there was a basis for payment at the time the claim was processed, the payment may stand. When the evidence indicates a payment was erroneous and not supported by law or regulation, the following action will be taken.

Recoupment Involving Issues Under Appeal - When the contractor examines claims which are related to the claim in dispute and determines that one or more of the related claims were improperly paid, the contractor shall explain the erroneous payment in detail and advise the appealing party of any recoupment. If the contractor determines recoupment is appropriate, the amount of the erroneously paid claim(s) will be added to the amount in dispute, and the reconsideration review will consider both the claim(s) in dispute and the erroneously paid related claim(s) which involve the same issue. If the total amount in dispute permits a higher level appeal, the appealing party will be so advised.

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TRICARE Operations Manual Chapter 12, Section 2 Governing Principals - Related Claims
When the contractor receives an appeal on a claim which has been denied, the contractor shall retrieve and examine all claims related to the specific service or supply or EOC received by the beneficiary to determine if the claim in dispute was properly denied and if related claims were properly processed. All claims which relate to the same incident of care or the same type of service to the beneficiary shall be processed in the same manner and shall be readjudicated and resolved along with the denied claim in the same reconsideration determination. If one claim which relates to an excluded procedure is denied, all claims which relate to the same procedure shall also be denied. If a procedure is covered and one claim involving that procedure and EOC is paid, other claims relating to the same procedure and/or period of care which have been denied should be examined in conjunction with the paid claim to see if the other claims may be paid or whether all the claims should be uniformly denied. The contractor shall take action in accordance with paragraph 4.4.2 to determine if any claim for the services or supplies was improperly paid or denied. All related claims shall be made part of the appeal file. The file shall contain full documentation pertaining to the issue and the care in dispute, to include a record of actions taken by the contractor on all claims involving the same issue.

# EXHIBIT G

Health Net®
FEDERAL SERVICES

TRICARE®

[redacted]

1/13/2016

**Revised Determination Letter**

[redacted]

| | | | |
|---|---|---|---|
| Beneficiary: | [redacted] | Appeal Type: | Prospective |
| Eligibility Status: | ADFM Prime | Inital Denial Type: | Factual (not a benefit) |
| Sponsor Name: | [redacted] | Dates of Service: | 12/5/2012 - 12/16/2015 |
| Sponsor SSN: | [redacted] | Authorization: | [redacted] |
| | | Authorization: | [redacted] |

**Care in Dispute:** Office Visits

**Providers Involved in Episode of Care:**

| Name | Status |
|---|---|
| Slucare Univeristy DBA Slucare, David Dempsher MD | Network |
| Cardinal Glennon Children's Hospital | Network |
| Dean L Rosen PHD, Dean Rosen PHD | Network |

Health Net Federal Services, LLC (Health Net) is the Managed Care Support contractor authorized by the TRICARE program to review health care services provided to TRICARE eligible beneficiaries residing in the North Region. Health Net has completed your appeal after thorough review of the care in dispute, applicable TRICARE regulations, additional information presented, and the opinion of the medical reviewers.

REVISION: Included all related claims and authorizations for review.

**Appeal Determination Summary**

Based upon TRICARE policy and the opinion expressed by the second reviewer, the initial denial is upheld as not a TRICARE benefit. Detailed rationale is provided in the Discussion section below.

[redacted]

## STATEMENT OF ISSUE

The following service(s) are under review: Office Visits. Authorization was requested for this care, and the initial reviewer denied the request as not a TRICARE benefit.

In addition to your appeal, there were concerns of TRICARE benefits.

## APPLICABLE AUTHORITY

TRICARE benefits are authorized by Congressional legislation incorporated in Chapter 55 of Title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in Title 32, Code of Federal Regulations, Part 199 (32 CFR 199). Specific regulation provisions pertinent to this case are set forth below. Also see additional applicable authorities enclosed.

TRICARE Policy Manual Chapter 1 Section 1.2 Exclusions
Authority:32 CFR 199.4(g)

1.0 POLICY
1.1 In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of the TRICARE Policy Manuals, the following specifically are excluded:

1.1.29 Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in 32 CFR 199.4(e)(7) (see Chapter 4, Sections 15.1, 16.1, 17.1, and Chapter 7, Section 1.1).

---

32 CFR 199.4(g)(29) Exclusions and limitations
Transsexualism or such other conditions as gender dysphoria.
Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in paragraph (e)(7) of this section.

32 CFR 199.4(e)(7)
Transsexualism or such other conditions as gender dysphoria.
All services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under CHAMPUS. This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender dysphoria. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, CHAMPUS benefits may be extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.

TRICARE Operations Manual Chapter 12 Section 2 Governing Principals

4.4 Erroneous Payments
In considering an issue under appeal, questions may arise concerning previous payment of services or claims not under appeal. Possible erroneous payments will be reviewed in depth, including medical review if necessary, to determine if, at the time the initial determination was made, there existed any basis for the payment. If the reviewer concludes there was a basis for payment at the time the claim was processed, the payment may stand. When the evidence indicates a payment was erroneous and not supported by law or regulation, the following action will be taken.

4.4.2 Recoupment Involving Issues Under Appeal
When the contractor examines claims which are related to the claim in dispute and determines that one or more of the related claims were improperly paid, the contractor shall explain the erroneous payment in detail and advise the appealing party of any recoupment. If the contractor determines recoupment is appropriate, the amount of the erroneously paid claim(s) will be added to the amount in dispute, and the reconsideration review will consider both the claim(s) in dispute and the erroneously paid related claim(s) which involve the same issue. If the total amount in dispute permits a higher level appeal, the appealing party will be so

[redacted]

advised.

TRICARE Policy Manual Chapter 7, Section 1.1 Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders
Authority:32 CFR 199.4(g)(30) and Title 10, United States Code (USC) 1079(a)(10)

2.0 POLICY
Diagnostic studies necessary to establish organic versus psychogenic disorders, and appropriate medical and surgical treatment related to sexual dysfunctions including sexual disinhibition with an organic origin (e.g., disease, trauma, injury, or radical surgery) may be cost-shared under the TRICARE Program.

3.0 EXCLUSIONS
3.1 Non-medical (psychiatric) services are not a benefit for organic sexual dysfunction.
3.2 Services and supplies provided in connection with psychotherapy for sexual dysfunctions, Paraphilias, and gender identify disorders are specifically excluded from cost-sharing. This includes therapy that is wholly or partially related to treating the sexual dysfunctions, paraphilias (e.g., transvestic fetishism) or gender identity disorder, such as sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy, or other similar services.

**DISCUSSION**

A request for reconsideration was received by Health Net and was presented to a second reviewer.

Materials Reviewed

The following were included in the review: the appeal request, any additional documentation submitted with your request, other supporting documentation, and the original denial information.

Initial Reviewer's Comments

The initial reviewer determined that the care in dispute was not a TRICARE benefit. The initial reviewer's comments were:

> Chapter 7, Section 1.1 of the TRICARE Policy Manual (TPM) excludes cost share for services and supplies provided in connection with psychotherapy for sexual dysfunction, paraphilias, and gender identity disorders. This includes therapy that is wholly or partially related to treating the sexual dysfunction, paraphilias (e.g. transvestite fetishism) or gender identity disorder, such as sex therapy, sexual counseling, sex behavior modification, psychotherapy, or other similar services.

Relevant Medical History

This is a 9-year-old male patient diagnosis of Gender Identity Disorder of Childhood [ICD10: F64.2]. The patient is stated to have consistent transgender (natal female-to-male) identity without dysphoria.

Second reviewer's comments:

> The parent of the beneficiary is appealing the denial of Office Consult and Visits [redacted] for Gender Identity Disorder of Childhood [ICD10: F64.2]. An authorization for service had been requested with the visits being denied on authorization number [redacted]. As part of the appeals process, Episode of Care (EOC) was reviewed. We have included all related authorizations and claims to these services, which includes office visits, hospital outpatient clinic visits, and psychotherapy visits, in this appeal for consideration
>
> TRICARE Policy Manual (TPM) Chapter 7 Section 1.1 pertains to Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders. This policy states that diagnostic studies necessary to establish organic versus psychogenic disorders, and appropriate medical and surgical treatment related to sexual dysfunctions including sexual disinhibition with an organic origin (e.g., disease, trauma, injury, or radical surgery) may be cost-shared under the TRICARE Program. However, services and supplies provided in connection with psychotherapy for sexual dysfunctions, Paraphilias, and gender identify disorders are specifically excluded from cost-sharing. This includes therapy that is wholly or partially related to treating the sexual dysfunctions, paraphilias (e.g., transvestic fetishism) or gender identity disorder, such as sex therapy, sexual advice, sexual counseling, sex behavior modification,

[redacted]

psychotherapy, or other similar services.

TPM Chapter 1 Section 1.2 excludes services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in 32 CFR 199.4(e)(7) (see Chapter 4, Sections 15.1, 16.1, 17.1, and Chapter 7, Section 1.1).

TRICARE Operations Manual (TOM) Chapter 12 Section 2 states that when the contractor receives an appeal on a claim which has been denied, the contractor shall retrieve and examine all claims related to the specific service or supply or EOC received by the beneficiary to determine if the claim in dispute was properly denied and if related claims were properly processed. All claims which relate to the same incident of care or the same type of service to the beneficiary shall be processed in the same manner and shall be adjudicated and resolved along with the denied claim in the same reconsideration determination. If one claim which relates to an excluded procedure is denied, all claims which relate to the same procedure shall also be denied. If a procedure is covered and one claim involving that procedure and EOC is paid, other claims relating to the same procedure and/or period of care which have been denied should be examined in conjunction with the paid claim to see if the other claims may be paid or whether all the claims should be uniformly denied. The contractor shall take action to determine if any claim for the services or supplies was improperly paid or denied. All related claims shall be made part of the appeal file. The file shall contain full documentation pertaining to the issue and the care in dispute, to include a record of actions taken by the contractor on all claims involving the same issue. Furthermore, in considering an issue under appeal, questions may arise concerning previous payment of services or claims not under appeal. Possible erroneous payments will be reviewed in depth, including medical review if necessary, to determine if, at the time the initial determination was made, there existed any basis for the payment. If the reviewer concludes there was a basis for payment at the time the claim was processed, the payment may stand. When the evidence indicates a payment was erroneous and not supported by law or regulation, the contractor may request a refund.

The reconsideration request is that of Office Consult and Visits [redacted] for patient with gender identity disorder. After reviewing the clinical notes along with the TRICARE policies as mentioned above, we are unable to make a favorable decision. Services related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs) are specifically excluded per policy; therefore, the initial denial is upheld. Since the related authorization and claims were all services related to such conditions, these claims are also denied and as such, these claims have been sent to our Claims Department for recoupment processing.

While we have determined that the services cannot be covered under TRICARE benefits, we found that there were concerns about the benefits and "unlawful discrimination" concerns due to benefit denial(s). In reviewing your case history, it shows our Grievance department has completed review of your concerns and a letter dated 12/22/2015 was mailed out to you. However, if you have further TRICARE appeal rights detailed in this letter and wish to appeal to the next level, you should follow the appeal instructions and file within the listed time frame.

**DECISION:**

Based upon TRICARE policy and the opinion expressed by the second reviewer, the initial denial is upheld as not a TRICARE benefit.

Claims to be recouped

The following claims were previously paid by TRICARE and are being recouped as a result of this reconsideration. Please review the Hold Harmless language in the Appeal Rights section for any services by network providers.

| Claim Number | Services From and To | | Recoup $ | Provider Name | Provider Status |
|---|---|---|---|---|---|
| [redacted] | 12/12/2012 | 12/12/2012 | $126.15 | David Dempsher MD | Network |
| [redacted] | 12/12/2012 | 12/12/2012 | $103.14 | Cardinal Glennon Children's Hospital | Network |

Appeal # 91433

| | | | | | |
|---|---|---|---|---|---|
| [redacted] | 12/5/2012 | 12/5/2012 | $101.00 | Dean Rosen PHD | Network |
| [redacted] | 12/21/2012 | 12/21/2012 | $77.00 | Dean Rosen PHD | Network |
| [redacted] | 1/3/2013 | 1/3/2013 | $77.00 | Dean Rosen PHD | Network |
| [redacted] | 2/8/2013 | 2/8/2013 | $77.00 | Dean Rosen PHD | Network |
| [redacted] | 2/28/2013 | 2/28/2013 | $77.00 | Dean Rosen PHD | Network |
| [redacted] | 4/3/2013 | 4/3/2013 | $49.31 | David Dempsher MD | Network |
| [redacted] | 4/3/2013 | 4/3/2013 | $80.87 | Cardinal Glennon Children's Hospital | Network |
| [redacted] | 4/10/2013 | 5/8/2013 | $154.00 | Dean Rosen PHD | Network |
| [redacted] | 6/19/2013 | 6/19/2013 | $77.00 | Dean Rosen PHD | Network |
| [redacted] | 7/17/2013 | 7/17/2013 | $77.00 | Dean Rosen PHD | Network |
| [redacted] | 8/14/2013 | 8/14/2013 | $77.00 | Dean Rosen PHD | Network |
| [redacted] | 10/24/2013 | 10/24/2013 | $75.97 | David Dempsher MD | Network |
| [redacted] | 10/24/2013 | 10/24/2013 | $70.32 | Cardinal Glennon Children's Hospital | Network |
| [redacted] | 4/3/2014 | 4/3/2014 | $51.12 | David Dempsher MD | Network |
| [redacted] | 4/3/2014 | 4/3/2014 | $87.78 | Cardinal Glennon Children's Hospital | Network |
| [redacted] | 10/29/2014 | 10/29/2014 | $78.46 | David Dempsher MD | Network |
| [redacted] | 10/29/2014 | 10/29/2014 | $87.78 | Cardinal Glennon Children's Hospital | Network |
| [redacted] | 6/3/2015 | 6/3/2015 | $91.85 | Cardinal Glennon Children's Hospital | Network |
| [redacted] | 6/3/2015 | 6/3/2015 | $50.54 | David Dempsher MD | Network |
| [redacted] | 12/16/2015 | 12/16/2015 | $91.43 | Cardinal Glennon Children's Hospital | Network |

Amount In Dispute

In accordance with 32 CFR. 199.10, there must be an amount in dispute for TRICARE to process a formal appeal. The amount in dispute is an esimate of the amount of money TRICARE would pay if the denied services and supplies were determined to be TRICARE benefits. The amount in dispute is the estimated allowed amount or the cost for the requested service. Related services (i.e. anesthesia and facility fees for a surgery) are not included in the amount in dispute for authorization denials as we cannot provide an accurate estimate of related charges.

The amount remaining in dispute after this reconsideration review is estimated to be $257.92

**APPEAL RIGHTS**

An administrative reconsideration review is available under the TRICARE appeal process when a denial is based on a requirement of law or regulation. However, because disputes challenging a requirement of law or regulation do not present an appealable issue, they are ineligible for appeal to a formal review or hearing. Since the disputed care in this case is excluded by law or regulation, further appeal is not authorized. This reconsideration determination completes the administrative appeal process under 32 CFR 199.10, and no further administrative appeal is available.

Although disputes challenging a requirement of law or regulation are not appealable to a formal review or hearing, further appeal to a formal review or hearing is available to dispute whether the law or regulation was properly applied if other requirements are satisfied, such as the requisite amount in dispute. For example, services and supplies related to treating obesity are excluded by law and regulation when obesity is the only or the major condition being treated. If a service or supply was provided to treat hypertension, but the obesity exclusion was erroneously applied, an appeal may be filed to challenge the erroneous application of the obesity exclusion. As a further example, if law or regulation excludes durable medical equipment, but the actual service provided was for a prosthetic device, an appeal may be filed on the grounds that the durable medical equipment exclusion was incorrectly applied to the prosthetic device coverage determination.

[redacted]

To dispute whether the law or regulation was properly applied a request for formal review must be postmarked or received by DHA within 60 days from the date of this notice.

Send your request for a formal review to:

Defense Health Agency (DHA)
Appeals and Hearings Division
16401 East Centretech Parkway
Aurora, CO 80011-9043

Services by Network Providers:
If any portion of the denied services is provided by a network provider, the beneficiary may be 'held harmless' from financial liability despite the service having been determined to be non-covered by TRICARE. A network provider cannot bill the beneficiary for non-covered care unless the beneficiary was informed in advance that the care was not covered by TRICARE, and waived their right to hold harmless by agreeing in advance, in writing to pay for the specific non-covered care. Under hold harmless, the beneficiary has no financial liability and therefore has no further appeal rights. However, If the beneficiary agreed in advance to waive their rights to hold harmless, the beneficiary would be financially liable and the appeal rights outlined above would apply.

[redacted]

If you have any questions regarding this notice or have questions about TRICARE benefits or eligibility, please contact Health Net at the following toll-free number and one of our associates will be happy to assist you.

Telephone Number: 1-877-TRICARE (1-877-874-2273)

Sincerely,

Kang Vang
TRICARE North Appeals

CC:

[redacted]

## ADDITIONAL APPLICABLE AUTHORITY REFERENCES:

TRICARE benefits are authorized by Congressional legislation incorporated in Chapter 55 of Title 10, United States Code, and implemented by the Secretary of Defense and the Secretary of Health and Human Services in Title 32, Code of Federal Regulations, Part 199 (32 CFR 199). Specific regulation provisions pertinent to this case are set forth below.

32 CFR 199.4(a)(1)(i) Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this part, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care and well-baby care. Benefits include specified medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

32 CFR 199.2(b) Defines appropriate medical care in pertinent part as that medical care where the services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care are in keeping with the generally accepted norms for medical practice in the United States and where the authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets CHAMPUS standards. The definition also specifies that the medical environment in which the medical services are performed is at the level adequate to provide the required medical care.

32 CFR 199.2(b) Defines medically or psychologically necessary in pertinent part as the frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

32 CFR 199.4(a)(5) Right to information. As a condition precedent to the provision of benefits, OCHAMPUS or its OCHAMPUS (contractors)...shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval of benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination or diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for pre-authorization or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determination, when necessary, which information will, subject to certain specific exclusions, be held confidential by the recipient.

32 CFR 199.4(g)(63) Non-covered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized provider are specifically excluded from the Basic Program.

32 CFR 199.10(a)(3) Burden of proof. The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this part to the authorization of CHAMPUS benefits, approval of authorized CHAMPUS provider status, or removal of sanctions imposed under Sec. 199.9 of this part. If a presumption exists under the provisions of this part or information constitutes prima facie evidence under the provisions of this part, the appealing party must produce evidence reasonably sufficient to rebut the presumption or prima facie evidence as part of the appealing party's burden of proof. CHAMPUS shall not pay any part of the cost or fee, including attorney fees, associated with producing or submitting evidence in support of an appeal.

32 CFR 199.4(g) Exclusions and limitations. In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this part, the following specifically are excluded from the Basic Program: (1) Not medically or psychologically necessary. Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy or well-baby care.

32 CFR 199.4(g) Exclusions and limitations. Note: The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

32 CFR 199.4(a)(13) Implementing instructions. The Director, OCHAMPUS, shall issue policies, procedures, instructions, guidelines, standards and/or criteria to implement 32 CFR 199.4.

TRICARE Operations Manual Chapter 12 Section 2 Governing Principals - Erroneous Payments

[redacted]

In considering an issue under appeal, questions may arise concerning previous payment of services or claims not under appeal. Possible erroneous payments will be reviewed in depth, including medical review if necessary, to determine if, at the time the initial determination was made, there existed any basis for the payment. If the reviewer concludes there was a basis for payment at the time the claim was processed, the payment may stand. When the evidence indicates a payment was erroneous and not supported by law or regulation, the following action will be taken.

Recoupment Involving Issues Under Appeal - When the contractor examines claims which are related to the claim in dispute and determines that one or more of the related claims were improperly paid, the contractor shall explain the erroneous payment in detail and advise the appealing party of any recoupment. If the contractor determines recoupment is appropriate, the amount of the erroneously paid claim(s) will be added to the amount in dispute, and the reconsideration review will consider both the claim(s) in dispute and the erroneously paid related claim(s) which involve the same issue. If the total amount in dispute permits a higher level appeal, the appealing party will be so advised.

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TRICARE Operations Manual Chapter 12, Section 2 Governing Principals - Related Claims
When the contractor receives an appeal on a claim which has been denied, the contractor shall retrieve and examine all claims related to the specific service or supply or EOC received by the beneficiary to determine if the claim in dispute was properly denied and if related claims were properly processed. All claims which relate to the same incident of care or the same type of service to the beneficiary shall be processed in the same manner and shall be readjudicated and resolved along with the denied claim in the same reconsideration determination. If one claim which relates to an excluded procedure is denied, all claims which relate to the same procedure shall also be denied. If a procedure is covered and one claim involving that procedure and EOC is paid, other claims relating to the same procedure and/or period of care which have been denied should be examined in conjunction with the paid claim to see if the other claims may be paid or whether all the claims should be uniformly denied. The contractor shall take action in accordance with paragraph 4.4.2 to determine if any claim for the services or supplies was improperly paid or denied. All related claims shall be made part of the appeal file. The file shall contain full documentation pertaining to the issue and the care in dispute, to include a record of actions taken by the contractor on all claims involving the same issue.

# EXHIBIT H

Health Net® FEDERAL SERVICES | TRICARE®

Date: May 27, 2016

Check prior authorization and referral status online!

Visit
**www.hnfs.com/go/bene/auth/status**

[redacted]

Sponsor Name: [redacted]
Patient ID:
Beneficiary Plan Type:
Beneficiary Date of Birth:
Beneficiary Phone Number:

**Referred To Provider:**
SLUCARE PEDIATRICS
1465 S GRAND BLVD
SAINT LOUIS, MO 63104 1003
Phone Number: 314-268-4035

Health Net Federal Services, LLC (Health Net) received a request from your provider for health care services. This request has been denied for coverage under the TRICARE® program.

Reference Number: [redacted]
Provider Specialty: Endocrinology

Diagnosis 1: F64.2 Gender identity disorder of childhood

| Service Type | Service Codes | Service Dates | Visits/Units |
|---|---|---|---|
| Office Visit Professional | 99201* - 99205 | 05/27/2016 - 08/25/2016 | 1 |
| Office Visit Professional | 99211* - 99215 | 05/27/2016 - 05/27/2017 | 5 |

* (99201) Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.







[redacted]

[redacted]

* (99211) Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Requesting Military Treatment Facility (MTF): SCOTT AFB MEDICAL CLINIC-375TH MED GRP
Requesting MTF Phone Number: 618-256-9355
Requesting MTF NPI: [redacted] Requesting MTF NPI Type Code: 2
Individual Requesting Provider: GUY VENUTI
Individual Requesting Provider [redacted] Individual Requesting Provider Type Code: 1

The decision to deny this request is based on the following reason:

Chapter 7, Section 1.1 of the TRICARE Policy Manual (TPM) excludes cost share for services and supplies provided in connection with psychotherapy for sexual dysfunction, paraphilias, and gender identity disorders. This includes therapy that is wholly or partially related to treating the sexual dysfunction, paraphilias (e.g. transvestite fetishism) or gender identity disorder, such as sex therapy, sexual counseling, sex behavior modification, psychotherapy, or other similar services.

When a service is found to be non-covered, help may be available from alternative resources. One of the most important sources is the provider who requested the service, as there may be a reasonable alternative medical treatment. When there are no specific medical alternatives for the non-covered service you may want to consider contacting local and national agencies that offer help for people with specific medical problems. Health Net has comprised a list of the most frequently requested non-covered services and possible resources for getting help in obtaining the service outside of your medical coverage. For more information visit the "Resources" page on our web site at the following address:

**www.hnfs.com**

Your appeal rights as a TRICARE beneficiary are outlined in the attachment "YOUR APPEAL RIGHTS." The information will explain what to do should you, your physician or the facility disagree with the denial decision.

If you have any questions regarding this notice, please feel free to contact us at the following toll-free number:

**Toll Free Telephone Number: 877-TRICARE (874-2273)**

Sincerely,

SABRINA LUTTRELL
TRICARE Site Administrator

cc: SCOTT AFB MEDICAL CLINIC-375TH MED GRP

[redacted]

Health Net® FEDERAL SERVICES | TRICARE®

## YOUR APPEAL RIGHTS

An appropriate appealing party who is dissatisfied with the initial denial determination relative to the services addressed in this letter, has the right to ask for a reconsideration of the denied services/procedure(s). According to TRICARE® guidelines, an appropriate appealing party is:

- The TRICARE beneficiary (including minors)
- The non-network participating provider of care
- The appointed representative of an appropriate appealing party

** Please note:*

- A custodial parent of a minor beneficiary is considered the "appointed representative" of the minor beneficiary until the beneficiary reaches 18 years of age (21 years of age for residents of Pennsylvania), at which time he/she must submit the appeal in their own behalf or appoint a representative (i.e., parent) in writing.
- A *"network"* provider is not an appropriate appealing party, however the *"network"* provider *may* be appointed by an appropriate appealing party to represent them in the TRICARE appeal.
- A Military Treatment Facility (MTF) provider or other employee of the United States Government is not a proper appealing party and, due to conflict of interest, *may not* be appointed as representative. An exception to this is made for an employee or member of a Uniformed Service who represents an immediate family member.

The following guidelines apply when requesting a reconsideration:

- The request must be in writing
- The request must be signed
- The request must include a copy of this determination letter
- **The request must be postmarked or received by the filing deadline outlined below in the instructions for requesting a "non-expedited reconsideration." For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service.**

The following guidelines apply to submitting or requesting *"additional documentation:"*

- Additional documentation in support of the appeal may be submitted. However, because a request for reconsideration must be postmarked or received within the timeframes outlined below, a request for reconsideration should not be delayed pending the acquisition of additional documentation. **You have the right to obtain copies of documents and information upon which our initial denial determination was made, however photocopying of requested documents and information could result in a reasonable charge for photocopies and first class postage.*

- If additional information is to be submitted at a later date, or if you would like additional time to review any requested documentation related to our initial denial, the letter requesting reconsideration must indicate this.

- **Unless your request for reconsideration indicates that there will be a delay due to reviewing additional documentation or submitting additional information, we will begin our reconsideration review/evaluation upon receipt of your request.**

**Please be aware:*

- If you decide to proceed with the denied service(s) addressed in this letter and the service(s) are provided by a *"network"* provider, you may be *"held harmless."* If you need assistance to determine if the provider is *"network"* you may contact us at 877-TRICARE (874-2273).

[redacted]

- A *"network"* provider cannot bill the beneficiary for non-covered care unless the following occurred:
  - You were notified that the services were not covered or, were not likely to be covered, by TRICARE and agreed in advance to pay for the services. An agreement to pay must be evidenced by written records. General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or excludable.
  - The beneficiary did not inform the provider that he/she was a TRICARE beneficiary.

- Under "hold harmless", you have no financial liability and therefore have no further appeal rights. However, if "hold harmless" does not apply as outlined above, you will be financially liable and the appeal instructions below apply.

**FILING YOUR APPEAL (RECONSIDERATION)**

**There are multiple types of appeals available under the TRICARE appeal process. However, only "non-expedited" appeal rights apply to benefit/factual denials.**

Instructions for filing your "non-expedited" reconsideration:
- The beneficiary, the appointed representative of the beneficiary or the "non-network" participating provider, must file the "non-expedited" reconsideration request. (See guidelines above).
- The request must be filed within ninety (90) calendar days from the date of this denial determination. (The denial determination letter should be included with the request).
- Once your request for reconsideration is received, all your TRICARE claims or relevant authorization requests for the entire course of treatment will be reviewed.
- Our reconsideration determination letter will be mailed to the appealing party within sixty (60) calendar days, not to exceed ninety (90) calendar days after the "non-expedited" appeal request is received.

Mail "non-expedited" reconsideration requests to:

Health Net -- TRICARE North
Authorization Appeals
P.O. Box 9530
Virginia Beach, VA 23450-9530

If you prefer, you may submit your request via:
- The confidential fax number: 888-881-3622.
- Health Net Federal Services secure website: **www.hnfs.com**. The Appeal page can be found under the Resources menu.

*Additional documentation in support of the web appeal can be faxed to: 888-881-3622 indicating "Additional Appeal Documentation" on fax cover.*

[redacted]

# EXHIBIT I

PGBA, LLC
TRICARE NORTH REGION CLAIMS
P.O. BOX 870140
SURFSIDE BEACH, SC 29587-9740

DUPLICATE COPY

Health Net® FEDERAL SERVICES | TRICARE®



[redacted]

March 28, 2016

Hello, [redacted]

Enclosed is your TRICARE Explanation of Benefits for services received.

Sincerely,

*Your TRICARE Service Team*

# Understanding Your TRICARE Explanation of Benefits (EOB)

This TRICARE EOB serves as a record of claims paid or denied and as a notice to send to secondary insurance carriers when applicable. Since the secondary insurance carrier may keep this notice, be sure to retain a copy for your records. If you submitted other claims that are not shown, they will be included on an EOB for the period in which the claim processed to completion.

Please review the services/supplies on the front of this EOB. If you find any services or supplies that you did not receive or that you were charged by a health care professional you did not see, please call the Health Net Fraud and Abuse Hotline at 1-800-977-6761.

**A. TRICARE Eligibility:** To be eligible for TRICARE benefits, you must have a valid military ID card, and you must be eligible on the Defense Enrollment Eligibility Reporting System (DEERS). Has your eligibilty or the eligibility of any of your dependents changed? The sponsor is responsible for reporting changes to Defense Enrollment Eligibility Reporting System (DEERS). If a claim is paid for an ineligible beneficiary, the sponsor may be held financially responsible. For issues related to eligibility, please call the DEERS office toll-free: 1-800-538-9552.

**B. Timely Filing:** TRICARE guidelines require claims to be filed within one year from the date of service ***or*** the discharge date for inpatient services. Claims are denied if received after the deadline. You may request a timely filing waiver by submitting documentation that verifies one of the following:

- Retroactive eligibility
- Retroactive Non-Availability Statement for inpatient mental health
- Mental incompetence when no legal guardian was appointed
- The date of the Explanation of Benefits from the patient's other health insurance is within 12 months of your submission
- Proof of claims submission before the filing time limit

Send your request for a timely filing waiver to:
Fax Number: 1-888-250-4510 OR
TRICARE North Region Priority
PO Box 870146
Surfside Beach, SC 29587-9746

**C. Patient Deductibles:** *TRICARE Standard patients* must meet their fiscal year deductible based on the sponsor's pay grade. *TRICARE Prime patients* do not have a deductible unless they choose the *Point of Service (POS)* option. POS allows a patient to see any certified TRICARE provider without coordinating an authorization or referral through their Primary Care Manager (PCM), but there are additional costs.

**Standard Coverage Deductible**

| *Active Duty E-4 and below* | *Retirees/Active Duty E-5 and above* |
|---|---|
| Individual - $50 | Individual - $150 |
| Family - $100 | Family - $300 |

**Prime Coverage POS Deductible**
Individual - $300
Family - $600
plus 50% cost-share

**D. Right To Appeal:** If you disagree with the determination on your claim, you have the right to request a reconsideration. Your signed, written request must state the specific matter with which you disagree and **MUST** be sent to the below Fax number or address No Later Than (NLT) 90 days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

**Only the following individuals may file an appeal:**

- The beneficiary (including minors)
- The parent or guardian representing a minor beneficiary
- The non-network participating provider of services
- A representative appointed by the proper appealing party
  (Must be in writing and be signed by the proper appealing party, or the representative must be court-appointed)

Please send all appeals and/or reconsiderations to
Fax Number: 1-888-458-2554 OR
TRICARE North Region Appeals
PO Box 2606
Virginia Beach, VA 23450-2606

NOTE: Claims denied for Active Duty Service Members require a DHA waiver. You must secure a DHA waiver before we can reconsider paying a service not covered by TRICARE. To obtain a waiver, contact your Service Project Officer at your Uniformed Services Headquarters.

**E. Non-appealable denials:** If you have a question about a non-appealable denial, please send to:
Fax Number: 1-888-432-7077 OR
TRICARE North Region Correspondence
PO Box 870141
Surfside Beach, SC 29587-9741 OR
Visit www.myTRICARE.com

NOTE: Claims denied for Active Duty Service Members require a DHA waiver. You must secure a DHA waiver before we can reconsider paying a service not covered by TRICARE. To obtain a waiver, contact your Service Project Officer at your Uniformed Services Headquarters.

**F. Authorizations/Referrals:** To see if an authorization or referral is required for a specific procedure, go to www.hnfs.com. Your provider can easily submit a request for prior authorization. For new Authorization/Referrals, please send to:
Fax Number: 1-888-299-4181 OR
TRICARE North Region Authorizations/Referrals
PO Box 9470
Virginia Beach, VA 23450-9470

**Grievances:** If a provider, employee of Health Net Federal Services, Inc. or its partners, failed to give you the quality of care and service to which you believe you are entitled, you may file a grievance. Your grievance must be filed in writing by you (or your representative). You may file your grievance with a TRICARE Advocate at your local TRICARE Service Center or send it to:
Fax Number: 1-888-317-6155 OR
TRICARE North Region Grievances
PO Box 2399
Virginia Beach, VA 23450-2399

**Additional Contact Information**

New Claims Submission
TRICARE North Region Claims
PO Box 870140
Surfside Beach, SC 29587-9740

To Report Suspected Fraud or Abuse
Fax Number: 1-888-881-3644 OR
TRICARE North Region Program Integrity
PO Box 10490
Virginia Beach, VA 23450-0490

Direct Secure Fax Numbers
Third Party Liability (TPL) Forms: 1-888-228-2717
Other Health Insurance (OHI) Updates: 1-888-237-6262
Authorizations to Disclose information: 1-888-225-3545

Corrected Claims or Correspondence
Fax Number: 1-888-432-7077 OR
TRICARE North Region Correspondence
PO Box 870141
Surfside Beach, SC 29587-9741

Customer Service Number
1-877-TRICARE (1-877-874-2273)

**IMPORTANT INFORMATION ABOUT TRICARE - NORTH REGION**

Your best sources for TRICARE claims information are www.hnfs.com and www.myTRICARE.com. You can save time as a registered member of *myTRICARE Secure.* With Web self-service options you can:

- Check claim status, authorization/referral status, PCM name, out-of-pocket expenses and Other Health Insurance (OHI) information
- View/print TRICARE Explanation of Benefits (EOB) and Annual Benefits Summaries
- Pay TRICARE enrollment fees
- *AskUs* confidential questions and receive quick answers in your secure *myTRICARE mailbox* and more

[redacted]

PGBA, LLC
TRICARE NORTH REGION CLAIMS
P.O. BOX 870140
SURFSIDE BEACH, SC 29587-9740

# TRICARE EXPLANATION OF BENEFITS

**This is a statement of the action taken on your TRICARE claim.**
**Keep this notice for your records.**

DUPLICATE COPY

Health Net FEDERAL SERVICES

TRICARE



**Date of Notice:** March 28, 2016
**Sponsor SSN:** [redacted]
**Sponsor Name:** [redacted]
**Beneficiary Name:** [redacted]

[redacted]

**Benefits were payable to:**

**ACCREDO HEALTH GROUP INC**
**PO BOX 99768**
**CHICAGO IL 60693**

**Claim Number:** [redacted]

| Services Provided By/ Date of Services | Services Provided | Amount Billed | TRICARE Approved | APC# | See Remarks |
|---|---|---|---|---|---|
| ACCREDO HEALTH GROUP INC | | | | | |
| 03/14/2016 | 001 Histrelin implant (supprelin (J9226) | 30,489.35 | 0.00 | | 1, 2, 3 |
| **Totals:** | | **30,489.35** | **0.00** | | |

**Claim Summary**

| | |
|---|---|
| Amount Billed: | 30,489.35 |
| TRICARE Approved: | 0.00 |
| Non-covered: | 30,489.35 |
| Paid by Beneficiary: | 0.00 |
| Other Insurance: | 0.00 |
| Paid to Provider: | 0.00 |
| Paid to Beneficiary: | 0.00 |
| Check Number: | |

**Beneficiary Liability Summary**

| | |
|---|---|
| Deductible: | 0.00 |
| Copayment: | 0.00 |
| Cost Share: | 0.00 |
| Patient Responsibility: | 0.00 |

**Benefit Period Summary**

**Fiscal Year Beginning:**
October 01, 2015

| | Individual | Family |
|---|---|---|
| Deductible: | 0.00 | 0.00 |
| Catastrophic Cap: | | 0.00 |

**Remarks:**

1 - NONCOVERED DIAGNOSIS. FOR INFORMATION ABOUT YOUR RIGHT TO APPEAL THIS DENIAL, PLEASE SEE BLOCK D ON THE BACK OF THIS SUMMARY.

2 - HAVE YOU CONSIDERED USING TRICARE PHARMACY HOME DELIVERY? COPAYMENTS ARE $0 FOR GENERIC FORMULARY MEDICATIONS. VISIT WWW.EXPRESS-SCRIPTS.COM/TRICARE AND CLICK ON THE PILL BOTTLE FOR MORE INFORMATION.

3 - DO YOU CURRENTLY USE TOBACCO AND WANT TO QUIT? TRICARE'S SMOKING CESSATION RESOURCES CAN BE FOUND BY VISITING WWW.HNFS.COM/GO/TOBACCO.

**1-877-TRICARE (1-877-874-2273)**

**THIS IS NOT A BILL**

**If you have questions regarding this notice, please call or write us at telephone number/address listed above.**

# EXHIBIT J

# Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

TO: All Insurers

FROM: Andrew Boron, Director

DATE: July 28, 2014

RE: Company Bulletin 2014-10
Healthcare for Transgender Individuals

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The purpose of this Bulletin is to provide Illinois-licensed insurance companies guidance regarding compliance with the nondiscrimination provisions applicable to transgender persons found in the Affordable Care Act, the Illinois Human Rights Act, and the Illinois Mental Health Parity Act. Together these laws prohibit discrimination against transgender persons because of their actual or perceived gender identity or health conditions. This prohibition extends to the availability of health insurance coverage, the provision of Essential Health Benefits, and the requirements for certification as a Qualified Health Plan.

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (together known as the Affordable Care Act (ACA)) and its implementing regulations prohibit discrimination in benefit design for plans offering the Essential Health Benefits (EHB) on the basis of gender identity and health conditions. 45 C.F.R. 156.125(b); 45 C.F.R. 156.200(e). In 2014, non-grandfathered small group and individual plans sold inside and outside of Illinois' federally-run Health Insurance Marketplace (Marketplace) will be subject to an EHB standard setting the minimum for what plans must cover. This standard is regulated by the state. Therefore the Illinois Department of Insurance (DOI) is responsible for implementing and enforcing the antidiscrimination protections applicable to EHB-based plans. Additionally, the ACA prohibits discrimination on the basis of gender identity and nonconformity with sex stereotypes in any health care program that receives federal financial assistance or is created under Title I of the ACA. 42 U.S.C. § 18116; Letter from Leon Rodriguez, Dir. of the Office for Civil Rights, U.S. Dep't. of Health & Human Servs. (Jul. 12, 2012) (OCR Transaction No. 12-000800), *available at* http://www.scribd.com/doc/101981113/Response-on-LGBT-People-in-Sec-1557-in-the-Affordable-Care-Act-from-the-U-S-Dept-of-Health-and-Human-Services. Finally, the ACA and its implementing regulations prohibit discrimination on the basis of gender identity with respect to Qualified Health Plans sold through Illinois' Marketplace. 42 U.S.C. § 18116; 45 CFR 156.200(e).

The Illinois Human Rights Act (IHRA) similarly prohibits discrimination on the basis of "actual or perceived … gender-related identity, whether or not traditionally associated with the person's designated sex at birth," 775 ILCS 5/1-103( O-1). The IHRA's non-discrimination mandate applies to the denial of "the full and equal enjoyment of the . . . goods, and services of any public place of accommodation," *id.* at 5/5-102(A), which includes the provision of insurance. *Id.* at 5/5-101(A)(6). The Illinois Insurance Code requires that an "insurer that amends, delivers, issues, or renews a group policy of accident and health insurance in this

State providing coverage for hospital or medical treatment and for the treatment of mental . . conditions" provide no more restrictive limitations on treatment for mental conditions, such as gender dysphoria or

gender identity disorder, than "the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy and that there are no separate treatment limitations that are applicable only with respect to mental … condition benefits." 215 ILCS 5/370c.1. However, sex change surgery may be excluded from excepted benefit policies and grandfathered health plans. 50 Ill. Adm. Code 2007.60(e)(13).

New policy filings or amended policy filings should comply with the nondiscrimination provisions in the ACA and Illinois law applicable to transgender Illinoisans that are cited above.

122 South Michigan 19th Floor
Chicago, Illinois 60603
(312) 814-2420

# STANDARDIZED TRANSGENDER NONDISCRIMINATION FORM

All individual and small group plans required to provide Essential Health Benefits (EHBs),including Qualified Health Plans (QHPs),, must not, discriminate on the basis of race, color, national origin, disability, age, sex, *gender identity* or sexual orientation. 45 CFR 156.200(e)(emphasis added); 45 CFR 125(b) (requiring plans providing Essential Health Benefits to comply with 45 CFR 156.200(e ); 775 ILCS 5-1-103(O-1) (prohibiting discrimination on the basis of gender-related identity); 215 ILCS 5/370c-1 (requiring equity in treatment for mental health conditions compared to medical conditions). The following insurance policy provisions or practices accordingly run the risk of being contrary to law or public policy under section 143(1) of the Illinois Insurance Code [215 ILCS 5/143(1)]:

**Surgical Treatment Coverage Discrimination**
Provisions that exclude from, limit, charge a higher rate, or deny a claim for coverage for the surgical treatments for gender dysphoria *that are provided to non-transgender persons* for other medical conditions, such as mastectomy and/or breast reconstruction after cancer.
Provisions that exclude from, limit, charge a higher rate, or deny a claim for coverage for emergency room care for complications from surgery for gender dysphoria, *if the company provides coverage for emergency room care for complications from surgery for other medical conditions.*

**Non-Surgical Treatment Coverage Discrimination**
Provisions that exclude from, limit, charge a higher rate, or deny a claim for coverage for hormone therapy for gender transition *if that treatment is provided for other medical conditions*, such as endocrine disorders or for women with menopausal symptoms.
Provisions that deny a transgender person coverage or benefits for sex-specific treatment, including but not limited to obstetrics and gynecology care, prostate exams, and mammograms, *because of their gender identity.*

**Discriminatory Exclusionary Clauses**
Exclusionary clauses or language that has the effect of *targeting transgender persons* or persons with gender dysphoria such as:

> "Any treatment or procedure designed to alter an individual's physical characteristics to those of the opposite sex."
>
> "Sex transformations and related services."
>
> "Sex change: Any treatment, drug, service, or supply related to changing sex or sexual characteristics."
>
> However, sex change surgery may be excluded from excepted benefit policies and grandfathered health plans. 50 Ill. Adm. Code 2007.60(e)(13).