IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
ATHENS DIVISION

SKYLER MUSGROVE,

Plaintiff,

v.

THE BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA, JAMES HULL, in his official capacity as Chair of the Board of Regents of the University System of Georgia, UNIVERSITY OF GEORGIA, JERE MOREHEAD, in his official capacity as President of the University of Georgia, KARIN ELLIOTT, in her official capacity as Interim Vice Chancellor of Human Resources of the University System of Georgia, BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC., METROPOLITAN LIFE INSURANCE COMPANY, and METLIFE, INC.

Defendants.

Civil Action No.

JURY TRIAL DEMANDED

COMPLAINT FOR DAMAGES

Plaintiff Skyler Musgrove, by and through his attorneys, files this Complaint against Defendants, the Board of Regents of the University System of Georgia, James Hull, in his official capacity as Chair of the Board of Regents of the University System of Georgia, University of Georgia, Jere Morehead, in his official capacity as President of the University of Georgia, Karin Elliott, in her official capacity as University System of Georgia Interim Vice Chancellor of Human Resources, Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Metropolitan Life Insurance Company, and MetLife, Inc., and respectfully states as follows:

INTRODUCTION

1. This case is about equal benefits for equal work. Plaintiff Skyler Musgrove ("Mr. Musgrove") works as a Catering and Banquets Manager at the University of Georgia. As part of its employment compensation, Defendant University of Georgia ("UGA") provides long- and short-term disability coverage and health care coverage, including the University System of Georgia Consumer Choice HSA Healthcare Plan ("Health Plan") that covers Mr. Musgrove.

2. Employees contribute part of their paychecks to the short-term disability plan and the Health Plan. Mr. Musgrove contributes the same amount as do his co-workers, but he receives unequal benefits in return. Employees generally receive coverage for their medically necessary care and disability-leave needs. In contrast, Mr. Musgrove has been forced to incur thousands of dollars in out-of-pocket costs to obtain medically necessary care without the financial protections afforded by the Health Plan or the short-term disability plan. This is because UGA expressly excludes the medical care he needs—not because the treatment isn't medically necessary or widely recognized as effective, but solely due to the historical stigmatization of his medical condition.

3. Mr. Musgrove has gender dysphoria, a serious medical condition and disability that arises when the sex of the brain develops on a divergent path from the external sex characteristics of the body. A well-established medical consensus finds that hormonal and surgical treatment to align external sex characteristics with the brain is successful in alleviating gender dysphoria. Accordingly, such medically necessary treatments are widely covered under public and private health insurance plans.

4. Mr. Musgrove suffers emotional distress, humiliation, and a loss of dignity because of this targeted discrimination and categorical dismissal of his medical needs.

5. Mr. Musgrove brings this action seeking declaratory and injunctive relief and damages caused by the discriminatory denial of medically necessary care and related disability leave.

JURISDICTION AND VENUE

6. This is a civil rights complaint for discrimination on the basis of disability and sex under the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101, et seq. ("ADA"), Section 504 of the Rehabilitation Act, 29 U.S.C. § 701 ("Section 504"), Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, et seq. ("Title VII"), Title I of the Civil Rights Act of 1991, 42 U.S.C. § 1981a, Title IX of the Educational Amendments of 1972, 20 U.S.C. § 1681, et. seq. ("Title IX"), and pursuant to 42 U.S.C. § 1983 for discrimination based on disability, sex, and transgender status in violation of the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution, U.S. Const. amend. XIV, § 1.

7. The Court has jurisdiction pursuant to Article III of the United States Constitution; 28 U.S.C. §§ 1331, 1343; and 42 U.S.C. § 2000e-5(f)(3).

8. Plaintiff's claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202 and 42 U.S.C. § 1983.

9. Under 28 U.S.C. § 1391, venue is proper in the Middle District of Georgia because Defendant University of Georgia resides and is subject to personal jurisdiction in the District and a substantial part of the events or omissions giving rise to the claim occurred in Athens, Georgia.

10. This action arises in the Athens Division because a substantial part of the events or omissions that give rise to the claim occurred at UGA's headquarters in Athens, Georgia.

PARTIES

11. Plaintiff Skyler Musgrove resides in Athens, Georgia.

12. The University of Georgia ("UGA") is a public institution of higher education. Its main campus is located in Athens, Georgia. UGA is part of the University System of Georgia, which is governed by the Board of Regents of the University of Georgia.

13. Jere Morehead, President of the University of Georgia, has his office in Athens, Georgia. Office of the President Administration Building 220 South Jackson Street Athens, Georgia 30602-1661

14. The Board of Regents of the University System of Georgia ("Board" or "Board of Regents"), an agency of the State of Georgia, has exclusive power over "[t]he government, control, and management of the University System of Georgia," Ga. Const. art. VIII, § 4, para. 1(b). The Board is headquartered in Atlanta, Georgia.

15. James Hull, is Chair of the Board of Regents of the University System of Georgia, which is headquartered in Atlanta, Georgia.

16. Karin Elliott is the Interim Vice Chancellor of Human Resources of the University System of Georgia. Her office is in Atlanta, Georgia.

17. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. ("BCBS") is a for-profit corporation organized under the laws of Georgia. It administers the Health Plan. It has a principle office address in Indianapolis, Indiana and its corporate headquarters are located in Atlanta, Georgia.

18. The University System of Georgia's disability insurance is administered by Metropolitan Life Insurance Company, a part of MetLife, Inc., a for-profit corporation organized under the laws of Delaware (both referred to collectively hereinafter as "MetLife"). MetLife, Inc.'s corporate headquarters are located in New York, New York.

19. At all relevant times, UGA is and has been a "person" and "employer" as defined under the ADA, Section 504, and Title VII and is accordingly subject to the provisions of each said act.

20. At all relevant times, the Board is and has been a "person" and "employer" as defined under the ADA, Section 504, and Title VII and is accordingly subject to the provisions of each said act.

21. The Board is a recipient of federal funds from the U.S. Department of Education, and, as such, is subject to Section 504 and Title IX.

22. UGA is a recipient of federal funds from agencies including the U.S. Department of Education, the U.S. Department of Agriculture, and the U.S. Department of Health and Human Services, and, as such, is subject to Section 504 and Title IX.

EXHAUSTION OF ADMINISTRATIVE REQUIREMENTS

23. On February 20, 2018, Plaintiff timely filed a charge with the Equal Employment Opportunity Commission against the Board, UGA, BCBS, and MetLife for sex discrimination in violation of Title VII and disability discrimination in violation of the ADA.

24. The right-to-sue, dated March 27, 2018, was postmarked March 28, 2018.

25. Mr. Musgrove brings this action within ninety (90) days of the March 31, 2018, receipt of a right-to-sue letter issued by the EEOC, a true and accurate copy of which is attached hereto as Exhibit A.

FACTUAL BACKGROUND

26. A nearly life-long resident with deep roots in Georgia, Mr. Musgrove began attending UGA in the Spring of 2008. He was a dual-degree student studying anthropology and mass media studies.

27. In approximately 2009, Mr. Musgrove was diagnosed with gender dysphoria. During his time as a UGA student, Mr. Musgrove publicly came out as a man and socially transitioned from female to male. He experienced challenges as a result of coming out as male—including being verbally and physically assaulted, both on and off campus. He was unable to focus on his studies and took two medical withdrawals. In 2012, he stopped attending school, just three courses shy of earning his degrees. He knew that medical transition was what would enable him to complete his studies.

28. As he was without health insurance, Mr. Musgrove decided to work full-time in order to save money for the surgery he needed to treat his gender dysphoria. Mr. Musgrove began working at UGA and has been employed continuously there since 2013. He has been promoted several times over the years and currently is a manager working in event planning.

Gender Dysphoria and its Treatment

29. The standard of care for treatment of gender dysphoria, established by the World Professional Association for Transgender Health ("WPATH"), the American Medical Association ("AMA"), the American Psychological Association ("APA"), and other major medical and mental health professional organizations, includes counseling, hormone therapy, gender reassignment surgery, as well as living openly as one's affirmed sex—in Mr. Musgrove's case, male.

30. Because gender dysphoria is readily treated through the use of hormones and surgery, it is widely covered under public and private health insurance plans. All major insurance companies have published clinical policy guidelines recognizing transgender surgeries as medically necessary and setting out basic standards that must be met before coverage is approved, such as a diagnosis of gender dysphoria, capacity to provide informed consent, and a letter of recommendation from a mental health provider.

31. A transgender person is someone whose external sex characteristics at birth do not match their brain sex or psychological sex—the innate, internal sense of being male or female, that all people have.[1] Typically, people born with the physical characteristics of males are psychologically male, and those with the physical characteristics of females are psychologically female. However, for a transgender person, body and brain do not match.

32. This incongruence results in gender dysphoria—i.e., a feeling of great stress and discomfort with the experience that something is fundamentally wrong. Such distress, if clinically significant and persistent, is a serious medical condition.

33. In 1980, the American Psychiatric Association introduced the diagnosis of gender identity disorder ("GID") in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). This diagnosis remained in subsequent versions of the DSM issued in 1987 (DSM-III-R) and 1994 (DSM-IV).

34. In 2013, the DSM-5 removed the diagnosis of GID and replaced it with a fundamentally different diagnosis called gender dysphoria that is based on significant changes in our understanding of individuals whose external sex characteristics at birth do not match their brain sex. Importantly, consistent with the change in nomenclature, the new diagnosis reflects that the incongruence between a person's brain sex and physical sex is no longer by itself considered to be a disorder, but rather the critical element of the condition is the presence of clinically significant distress that results from such an incongruence.

[1] Brain sex, sometimes referred to as "gender identity," is often invisible to people whose psychological sex matches their external sex characteristics. It can be made more visible through a thought experiment of asking how much money someone would have to pay you to transition socially, medically, and legally and live as the other sex for the rest of your life.

35. There is now a scientific consensus that brain sex is biologically based, and a significant body of scientific and medical research that gender dysphoria has a physiological and biological etiology that emanates from an atypical interaction of sex hormones with the developing brain.[2] The scientific evidence also demonstrates different brain composition in transgender women and men, and a significant co-occurrence of gender dysphoria in families and twins.

36. The World Professional Association for Transgender Health ("WPATH") is an interdisciplinary professional and educational organization devoted to transgender health. WPATH has established internationally-accepted *Standards of Care* ("SOC") for the treatment of people with gender dysphoria. Major medical and mental health organizations, including the American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association, have endorsed the SOC as the authoritative standards of care.

37. The treatment for gender dysphoria is to assist the person in undergoing a gender transition that will alleviate the distress caused by gender dysphoria and allow the person to live in alignment with the person's affirmed sex. When left untreated, gender dysphoria can result in serious psychological debilitation, including depression, anxiety, suicidality, and other mental health issues.

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[2] *See, e.g., See, e.g.,* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 457 (5th ed. 2013) (discussing genetic and hormonal contributions to gender dysphoria); Christine Michelle Duffy, *The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973, in* GENDER IDENTITY AND SEXUAL ORIENTATION DISCRIMINATION IN THE WORKPLACE: A PRACTICAL GUIDE 16-72 to 16-74 & n.282 (Christine Michelle Duffy ed., Bloomberg BNA 2014) (citing numerous medical studies conducted in past eight years that "point in the direction of hormonal and genetic causes for the in utero development of Gender Dysphoria").

38. The transition process has three main components—social, pharmacological, and surgical:

a. Social transition involves bringing a person's gender expression and social sex role into alignment with their affirmed sex. It may include wearing clothes, using a different name and pronouns, and interacting with peers and one's social environment in a manner that matches the person's affirmed sex.

b. A transgender person may also decide to take medications that change the hormone balance in their bodies to be consistent with the person's affirmed sex. For example, a transgender man would take medications that reduce estrogen and replace those hormones with testosterone, which will further masculinize that person's sex characteristics.

c. Lastly, a transgender person may pursue surgical treatment to alleviate dysphoria caused by having incongruent primary and secondary sex characteristics.

39. The precise medical treatments required to alleviate a particular individual's gender dysphoria may vary based on the person's individualized medical needs.

Defendants' Denial of Mr. Musgrove's Medically Necessary Care

40. When he was made a full-time employee in September 2015, Mr. Musgrove had one month to choose a benefits package. He asked Human Resources which plan would cover his treatments for gender dysphoria. He was informed that all health plans had a list of excluded treatments, which included treatments for gender dysphoria, so no matter which plan he chose, he would be denied coverage for the care that he needed.

41. Mr. Musgrove reached out to Monica P. Fenton, Director of System Benefits—Healthcare & Pharmacy, of the Board of Regents of the University System of Georgia. He requested to address the Board and ask that the exclusion be removed. He received no response.

42. Human Resources also informed Mr. Musgrove that his short-term disability insurance would not provide coverage for surgery to treat gender dysphoria. He would have to rely on his personal vacation and medical leave time to have an income during recovery. He began forgoing as many vacation and sick days as possible while attempting to accumulate as many days off as possible to allow for recovery from surgery.

43. In 2017, Mr. Musgrove was covered under the University System of Georgia Consumer Choice HSA Healthcare Plan. He is currently covered under the 2018 version of the same plan. This health plan is offered to all full-time UGA employees. As with other Health Plan participants, he currently contributes $75.12 per month for health benefits.

44. The Health Plan covers medically necessary prescription drugs and surgery including physician services, anesthesia, and hospital expenses. Yet the Health Plan explicitly excludes the following services: "Sex Change – Services or supplies for a sex change and/or the reversal of a sex change," and "Sex Change Drugs – Drugs for sex change surgery."[3] (Exhibit B at 53, 98.) These exclusions remain in the 2018 plan. But for these exclusions, gender dysphoria treatments would be covered under the plan on the same terms as any other widely-recognized, medically necessary care.

[3] "Sex change" is an archaic and disfavored term that is not used in the medical community. Under contemporary medical and psychological understanding, gender dysphoria-related medical treatments make visible, but do not "change," an individual's sex by bringing primary and secondary sex characteristics into alignment with the person's brain sex.

45. As a UGA employee, Mr. Musgrove also participates in the Board's Disability Income Insurance: Short Term Benefits and Long Term Benefits plan ("Disability Insurance"). This short and long-term disability income insurance is offered to all full-time UGA employees. As with other Disability Insurance participants, Mr. Musgrove currently contributes $6.03 per biweekly paycheck for short-term disability benefits. The Disability Insurance plan administered by MetLife contains an exclusion for short term benefits for any disability caused by "sex-change surgery." (Exhibit C at 51.)

46. Mr. Musgrove required surgery to treat his gender dysphoria. Mr. Musgrove had a long-standing, debilitating discomfort with his typically female chest. To alleviate the gender dysphoria caused by his chest, he bound his breasts to establish a flat, typically male chest. Mr. Musgrove bound his chest for a period of nine years, which restricted his breathing, made it not possible to engage in physical exercise, and contributed to a persistent dry couch.

47. In 2012, Mr. Musgrove started testosterone therapy to help alleviate his gender dysphoria. As a result, he developed a typical male appearance and secondary sex characteristics, including a full beard and a typically male voice. This heightened his need for chest surgery as having typically female breasts on a male not only exacerbated his gender dysphoria, it also presented a safety risk when in public. Mr. Musgrove experienced anxiety and a withdrawal from social activities due to his chest dysphoria. He also experienced a loss of concentration and ability to focus and learn.

48. After accruing days off, Mr. Musgrove located a qualified surgeon experienced with performing chest surgery to treat gender dysphoria. On February 7, 2017, Mr. Musgrove had a telephone consultation with his surgeon, Dr. Hope Sherie, who is located in Charlotte, North Carolina.

49. On April 19, 2017, Mr. Musgrove's surgeon applied for preauthorization with BCBS. In a letter dated April 26, 2017, BCBS declined to preauthorize coverage for surgery stating, "We cannot approve your request for coverage of breast removal for transgender surgery. This request is not covered by your plan. It is listed as an excluded benefit in your certificate of coverage manual, page 53 and 55." (Exhibit D.)

50. Mr. Musgrove underwent surgery to treat gender dysphoria on May 30, 2017. Mr. Musgrove's surgeon was an out-of-network provider with BCBS but assisted Mr. Musgrove with submitting the claim to BSBS. Mr. Musgrove learned he suffered financial injury after receiving an Explanation of Benefits dated October 10, 2017. BCBS denied the $8333.32 claim for surgery stating, "This is not a covered expense of the patient's plan." (Exhibit E.)

51. On April 7, 2018, Mr. Musgrove appealed the denial of his claim. In a letter dated April 24, 2018, BCBS denied his appeal stating that because the plan is self-insured, it had "no flexibility" to override the plan exclusion. (Exhibit F.)

52. BCBS denied coverage despite the fact that, in general, BCBS recognizes the medical necessity of surgery to treat gender dysphoria. Since 2006, Blue Cross Blue Shield of Georgia has had a medical policy on Sex Reassignment Surgery.[4] It details the criteria—which Mr. Musgrove has met—that determine when gender reassignment surgery is medically necessary for a given individual. But for the exclusion, BCBS would have approved his surgery as medically necessary.

[4] Blue Cross Blue Shield of Georgia, Clinical UM Guideline CG-SURG-27: Sex Reassignment Surgery (Aug. 17, 2017), https://www.bcbsga.com/medicalpolicies/guidelines/gl_pw_a051166.htm.

53. Mr. Musgrove has paid out of pocket for a medically necessary procedure and he has not been reimbursed. He previously and currently pays into an insurance plan that does not cover him to the same extent it covers his coworkers based on his disability and sex.

54. Mr. Musgrove did not apply for short-term disability for his surgery because Human Resources told him he was not eligible. They did not provide the paperwork to apply. He had to use his personal vacation and medical days off during his surgery recovery. Mr. Musgrove was denied the opportunity to receive short-term disability income following a medically necessary surgery. He previously and currently pays into an insurance plan that does not cover him to the same extent it covers his coworkers based on his disability and sex.

55. Mr. Musgrove took steps to resolve the issue including speaking with Human Resources, filing a claim and appeal with BCBS, and contacting via counsel UGA's General Counsel and the Legal Department of the Board of Regents. He also submitted via counsel a request to Chancellor Steve Wrigley to appear to raise the issue at the January 11, 2018, meeting of the Board of Regents, the body responsible for determining coverage. He was denied an in-person appearance and submitted written materials only.

56. When he went to re-enroll for benefits during the open enrollment period at the end of 2017, Mr. Musgrove asked Human Resources if there had been any changes in coverage for treatments of gender dysphoria. He was informed there were not, so he remained on the Health Plan.

57. UGA offers four different health plans to all employees to allow them to make the best choice for themselves in terms of provider network, premium cost, and cost-sharing. In a letter dated February 12, 2018, Karin Elliott acknowledged that all three self-funded health care plans offered by the University System of Georgia exclude treatments for gender dysphoria. (Exhibit G.)

All of the Board's self-funded health plans are administered by BCBS, but Ms. Elliott stated that the Kaiser Permanente HMO did not have an exclusion.

58. Although he asked, Human Resources did not inform Mr. Musgrove about the Kaiser Permanente HMO plan prior to undergoing surgery or prior to enrolling in the 2018 plan.

59. The vast majority of UGA employees choose one of the self-funded BCBS plans. Mr. Musgrove is denied the same range of choices as non-transgender co-workers because only one plan does not exclude the medically necessary care that he needs. Contracting with one third-party HMO that does not discriminate in its plan while the Board persists in excluding medically necessary care does not address the inequity in plan choices, plan coverage, or the stigma caused by having exclusions at all. The simple existence of "sex change" exclusions—which lack a legitimate, nondiscriminatory basis—devalues the medical needs of Mr. Musgrove and all employees with gender dysphoria and contributes to a hostile work environment on the basis of disability and sex.

60. Mr. Musgrove would also be harmed by being forced to switch to the Kaiser HMO. There is dearth of providers who are experienced treating transgender patients, and Mr. Musgrove has had negative experiences with providers unfamiliar with transgender patients. Switching to the Kaiser HMO would force him to switch primary care providers, use a limited network of physicians, pay a monthly premium that is over twice as much, and he would have an extremely narrow choice of surgeons in the Kaiser network to perform the specialized surgeries to treat gender dysphoria that he still requires.

61. The discrimination against Mr. Musgrove remains on-going as long as the exclusions for gender dysphoria treatments remain in the self-funded health plans and Disability Insurance. Mr. Musgrove requires additional surgeries to treat his gender dysphoria. He also needs

prescription drug coverage for his on-going testosterone therapy, but this is also excluded under the plan. As a result of the Health Plan and Disability Insurance exclusions, Mr. Musgrove is forced to either forego medically necessary treatment due to a lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

FIRST CAUSE OF ACTION

Unlawful Discrimination on the Basis of Disability in Violation of Title I of the Americans with Disabilities Act

Against All Defendants (for compensatory damages, declaratory relief, and injunctive relief)

62. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

63. Title I of the ADA provides that "[n]o covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." 42 U.S.C. § 12112(a).

64. Under Title I of the ADA, a "covered entity" means a person—including "one or more individuals, governments, [or] governmental agencies," 42 U.S.C. § 2000e—"engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, *and* any agent of such person . . . ." 42 U.S.C. §§ 12111(2), (5)(A), (7) (citing 42 U.S.C. § 2000e).

65. Under Title I of the ADA, a "qualified individual" means an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." 42 U.S.C. §§ 12111(8).

66. Title I of the ADA prohibits disparate treatment of a qualified individual with a disability, including: (i) "limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee"; (ii) "participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity's qualified applicant or employee with a disability to the discrimination prohibited by this subchapter (such relationship includes a relationship with an employment or referral agency, labor union, an organization providing fringe benefits to an employee of the covered entity, or an organization providing training and apprenticeship programs)"; and (iii) "excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association." 42 U.S.C. § 12111(b)(1)-(2), (4); *see also* 29 C.F.R. §§ 1630.4 - 1630.8.

67. Title I of the ADA prohibits conduct that has a disparate impact on a qualified individual with a disability, including: (i) "utilizing standards, criteria, or methods of administration . . . that have the effect of discrimination on the basis of disability"; and (ii) "using qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity." 42 U.S.C. § 12111(b)(3), (6); *see also* 29 C.F.R. §§ 1630.7, 1630.10.

68. Title I of the ADA prohibits "not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would

impose an undue hardship on the operation of the business of such covered entity; or . . . denying employment opportunities to a job applicant or employee who is an otherwise qualified individual with a disability, if such denial is based on the need of such covered entity to make reasonable accommodation to the physical or mental impairments of the employee or applicant. 42 U.S.C. § 12111(b)(5); *see also* 29 C.F.R. § 1630.9.

69. Because of the date of the actions complained of, the expanded definition of "disability" under the Americans with Disabilities Act Amendments Act of 2008 ("ADAAA") applies.

70. Under the ADAAA and EEOC regulations interpreting the ADA, as amended, the definition of disability is to be construed broadly in favor of expansive coverage. 42 U.S.C. § 12102(4)(A); 28 C.F.R. §§ 35.108(a)(2)(i), 35.108(d)(1)(i). Accordingly, the terms "substantially" and "major" in the definition of disability are to be interpreted consistently with the ADAAA's findings and purposes, which reinstate "the broad scope of protection intended to be afforded by the ADA" and convey Congress's intent "that the question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis." 42 U.S.C. §§ 12102(4)(B), ADA Amendments Act of 2008, Pub. L. No. 110-325, §§ (2)(a)(5), (b)(5).

71. In determining disability, the ADAAA requires that impairments must be assessed "without regard to the ameliorative effects of mitigating measures," such as medication, therapy, and reasonable accommodations. 42 U.S.C. § 12102(4)(E)(i).

72. In determining disability, the ADAAA requires that impairments that are "episodic or in remission" must be assessed in their active state. 42 U.S.C. § 12102(4)(D).

73. In determining disability, a "major life activity" includes "the operation of a major bodily function," including neurological, brain, and reproductive functions. 42 U.S.C. § 12102(2)(B); *see also* 29 C.F.R. § 1630.2(i).

74. Under the ADAAA and regulations interpreting the ADA, as amended, "an individual meets the requirement of 'being regarded as having' an impairment that substantially limits one or more major life activities if the individual establishes that he or she has been subjected to an action prohibited under th[e ADA] because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity." 42 U.S.C. §§ 12102(3)(A); *see also* 29 C.F.R. § 1630.2(l); ADA Amendments Act of 2008, Pub. L. No. 110-325, § (2)(b)(3) (reinstating "broad view of the third prong" of the definition of disability). Accordingly, no showing of substantial limitation of a major life activity is required under the regarded-as prong. 29 C.F.R. § § 1630.2(g)(3) ("[T]he 'regarded as' prong of the definition of disability . . . does not require a showing of an impairment that substantially limits a major life activity or a record of such an impairment.").

75. UGA and the Board are covered entities within the meaning of Title I of the ADA.

76. BCBS, and MetLife, as agents of UGA and the Board, are covered entities within the meaning of Title I of the ADA. *See* EEOC COMPLIANCE MANUAL, No. 915.003, 2-III(B)(2)(b) (2000), https://www.eeoc.gov/policy/docs/threshold.html ("An entity that is an agent of a covered entity is liable for the discriminatory actions it takes on behalf of the covered entity. For example, an insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent.").

77. UGA and the Board violated Title I of the ADA by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Adopting a healthcare policy that excludes treatment for gender dysphoria, and participating in a contractual or other arrangement or relationship with BCBS and MetLife that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Title I of the ADA.

b. Adopting a healthcare policy that has the effect of discrimination on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably accommodate Mr. Musgrove by modifying the healthcare policy to include treatment for gender dysphoria.

78. BCBS, and MetLife violated Title I of the ADA by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Offering a healthcare policy that excludes treatment for gender dysphoria, and participating in a contractual or other arrangement or relationship with UGA and the Board that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Title I of the ADA.

b. Offering a healthcare policy that has the effect of discriminating on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably accommodate Mr. Musgrove by modifying the healthcare policy to include treatment for gender dysphoria.

79. Mr. Musgrove is a qualified individual under Title I of the ADA because he can perform the essential functions of his job, with or without reasonable accommodation.

80. Mr. Musgrove has a disability within the meaning of the ADA, as amended.

81. Mr. Musgrove suffers from gender dysphoria, which is a "physical or mental impairment" under the ADA. *See* 29 C.F.R. § 1630.2(h); *see also* 28 C.F.R. §§ 35.108(b)(1), 36.105(b)(1).

82. Gender dysphoria is not excluded under the ADA, 42 U.S.C. § 12211(b)(1) (excluding from definition of disability "gender identity disorders not resulting from physical impairments"), because gender dysphoria is a gender identity disorder "that results from [a] physical impairment[]." *Id.* The burgeoning medical research underlying gender dysphoria points to a physical etiology—namely, an atypical interaction of sex hormones and the developing brain that results in a person being born with circulating hormones inconsistent with the person's brain sex.[5] This atypical interaction of sex hormones and the brain is a "physiological . . . condition . . . affecting one or more body systems," including "neurological . . . [and] endocrine" systems. 29 C.F.R. § 1630.2(h)(1); *see also* 28 C.F.R. §§ 35.108(b)(1)(i), 36.105(b)(1)(i). In 2015, the U.S. Department of Justice concluded that:

> While no clear scientific consensus appears to exist regarding the *specific* origins of gender dysphoria (*i.e.*, whether it can be traced to neurological, genetic, or hormonal sources), the current research increasingly indicates that gender dysphoria has physiological or biological roots. . . . [i]n light of the evolving scientific evidence suggesting that gender dysphoria may have a physical basis, along with the remedial nature of the ADA and the relevant statutory and regulatory provisions directing that the terms 'disability' and 'physical impairment' be read broadly, the [ADA's exclusion of gender identity disorders not resulting from physical impairments] should be construed narrowly such that gender dysphoria falls outside its scope.

[5] *See, e.g.*, AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 457 (5th ed. 2013) (discussing genetic and hormonal contributions to gender dysphoria); Christine Michelle Duffy, *The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973*, *in* Gender Identity and Sexual Orientation Discrimination in the Workplace: A Practical Guide 16-72 to 16-74 & n.282 (Christine Michelle Duffy ed., Bloomberg BNA 2014) (citing numerous medical studies conducted in past eight years that "point in the direction of hormonal and genetic causes for the in utero development of gender dysphoria").

Second Statement of Interest of the United States at 5, *Blatt v. Cabela's Retail, Inc.*, No. 5:14-cv-4822-JFL, 2015 WL 9872493 (E.D. Pa. Nov. 16, 2015) (emphasis added). The United States has maintained this position in two additional cases.[6]

83. Alternatively, gender dysphoria is not excluded under the ADA because it is *not* a "gender identity disorder" under 42 U.S.C. § 12211(b)(1)—it is a new and distinct diagnosis. In 2013, the DSM-5 replaced the diagnosis of "gender identity disorders" with gender dysphoria. This replacement was more than semantic; it reflects a substantive difference between the medical conditions themselves. Unlike the outdated diagnosis of gender identity disorder, the hallmark or presenting feature of gender dysphoria is not a person's gender identity. Rather, it is the clinically significant distress, termed dysphoria, that some people experience as a result of the mismatch between a person's gender identity and their assigned sex. Reflecting this distinction, the diagnostic criteria for gender dysphoria in the DSM-5 are different than those for gender identity disorder. Indeed, there are people with gender dysphoria that would not meet the criteria for gender identity disorder. Furthermore, the diagnosis of gender dysphoria rests upon a growing body of new scientific research showing that gender dysphoria has a physical cause. *See* DSM-5, *supra*, note 5 (discussing possible genetic and physiological underpinnings of gender dysphoria).

84. Alternatively, gender dysphoria is not excluded under the ADA because it is not a "gender identity disorder," as that term is used in 42 U.S.C. § 12211(b)(1). As the U.S. District Court for the Eastern District of Pennsylvania held in *Blatt v. Cabela's Retail, Inc.*, "gender identity disorder" in the ADA refers simply to transgender identity (i.e., "the condition of identifying with a different gender")—not to medical conditions like gender dysphoria that

[6] *See* Stat. of Int. of U.S. at 2-3, *Doe v. Dzurenda*, No. 3:16-CV-1934 (D. Conn. Oct. 27, 2017), ECF No. 57; Stat. of Int. of U.S. at 2-3, *Doe v. Arrisi*, No. 3:16-cv-08640 (D.N.J. July 17, 2017), ECF No. 49.

transgender people may have. *Blatt v. Cabela's Retail, Inc.*, 2017 WL 2178123, at *4 (E.D. Pa. 2017); *see id.* at 3 n.3 (likening "gender identity disorder" to "homosexual[ity] or bisexual[ity]," none of which are medical conditions covered by the ADA); *see also* Kevin Barry & Jennifer Levi, "*Blatt v. Cabela's Retail, Inc.* and a New Path for Transgender Rights," 127 YALE L.J. FORUM 373, 385 (2017) (discussing *Blatt*'s holding).

85. Mr. Musgrove's gender dysphoria substantially limits one or more major life activities, including his ability to care for himself, eating, sleeping, learning, concentrating, thinking, communicating, interacting with others, and reproducing, and also substantially limits the operation of major bodily functions, including neurological function, brain function, and reproductive function.

86. Mr. Musgrove has a record of gender dysphoria, which substantially limits one or more major life activities, including his ability to care for himself, eating, sleeping, learning, concentrating, thinking, communicating, interacting with others, and reproducing, and also substantially limits the operation of major bodily functions, including neurological function, brain function, and reproductive function.

87. Mr. Musgrove "meets the requirement of 'being regarded as having' an impairment that substantially limits one or more major life activities" because UGA and the Board have adopted a healthcare policy that excludes treatment for gender dysphoria, they have participated in a contractual or other arrangement or relationship with BCBS and MetLife that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Title I of the ADA, and they have adopted a healthcare policy that has the effect of discriminating on the basis of gender dysphoria, and that screens out or tends to screen out individuals with gender dysphoria.

88. Mr. Musgrove "meets the requirement of 'being regarded as having' an impairment that substantially limits one or more major life activities" because BCBS and MetLife have offered a healthcare policy that excludes treatment for gender dysphoria, they have participated in a contractual or other arrangement or relationship with UGA and the Board that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Title I of the ADA, and they have offered a healthcare policy that has the effect of discriminating on the basis of gender dysphoria, and that screens out or tends to screen out individuals with gender dysphoria.

89. As a result of Defendants' actions and failure to accommodate, Mr. Musgrove has been forced to either forego medically necessary treatment due to lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

SECOND CAUSE OF ACTION

Unlawful Discrimination on the Basis of Disability in Violation of Title II of the Americans with Disabilities Act
Against UGA and Board of Regents
(for compensatory damages, declaratory relief, and injunctive relief)

90. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

91. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity," 42 U.S.C. § 12132(a), including discrimination in the provision of "any aid, benefit, or service . . . directly or through contractual, licensing, or other arrangements, on the basis of disability . . . ." *Id.* at 12132(b); U.S. DEP'T OF JUSTICE, GUIDANCE ON ADA REGULATION ON NONDISCRIMINATION ON THE BASIS OF DISABILITY IN STATE AND LOCAL GOVERNMENT SERVICES ORIGINALLY

PUBLISHED JULY 26, 1991, 28 C.F.R. Pt. 35, App. B § 35.102 ("All governmental activities of public entities are covered, even if they are carried out by contractors.").

92. In particular, under Title II of the ADA, "[n]o qualified individual with a disability shall, on the basis of disability, be subjected to discrimination in employment under any service, program, or activity conducted by a public entity." 28 C.F.R. § 35.140(a); *see also Bledsoe v. Palm Beach County Soil and Water Conservation Dist.*, 133 F.3d 816, 822 (11th Cir. 1998) ("Title II of the ADA encompasses public employment discrimination.").

93. "The requirements of title I of the [ADA], as established by the regulations of the Equal Employment Opportunity Commission in 29 CFR part 1630," are applicable to employment discrimination by a public entity, provided that "the public entity is also subject to the jurisdiction of title I." 28 C.F.R. § 35.140(b)(1).

94. Under Title II of the ADA, a "public entity" means "any State or local government" or "any department, agency, special purpose district, or other instrumentality of a State or States or local government." 42 U.S.C. § 12131(1)(A)-(B).

95. UGA and the Board are "public entit[ies]" within the meaning of Title II of the ADA.

96. The requirements of Title I of the ADA and EEOC regulations implementing the ADA, as amended, are applicable to employment discrimination by UGA and the Board because these entities are "covered entit[ies]" subject to the jurisdiction of Title I of the ADA, as set forth above in Paragraph 18.

97. As set forth above in Paragraphs 77, UGA and the Board violated Title I of the ADA by discriminating against Mr. Musgrove on the basis of his disability.

98. As set forth above in Paragraph 79, Mr. Musgrove is a qualified individual under Title I of the ADA.

99. As set forth above in Paragraphs 85 to 88, Mr. Musgrove has a disability, gender dysphoria, within the meaning of the ADA, as amended. *See* 28 C.F.R. § 35.108 (Title II regulations interpreting definition of disability under ADA).

100. As a result of UGA's and the Board's actions and failure to accommodate, Mr. Musgrove has been forced to either forego medically necessary treatment due to lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

THIRD CAUSE OF ACTION

Unlawful Discrimination on the Basis of Disability in Violation of Title III of the Americans with Disabilities Act

Against Defendants BCBS and MetLife (declaratory relief, and injunctive relief)

101. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

102. Title III of the ADA provides that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. § 12182.

103. Under Title III of the ADA, "insurance offices" whose operations affect commerce are places of public accommodation, 42 U.S.C. § 12181(7)(F), "and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer." U.S. DEP'T OF JUSTICE, ADA TITLE III TECHNICAL ASSISTANCE

MANUAL, COVERING PUBLIC ACCOMMODATIONS AND COMMERCIAL FACILITIES III-3.11000, https://www.ada.gov/taman3.html.

104. Title III of the ADA prohibits disparate treatment of an individual on the basis of disability, including, "directly or through contractual, licensing, or other arrangements": (i) denying an individual the opportunity "to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity" on the basis of disability; (ii) affording an individual the opportunity "to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals"; (iii) providing an individual "with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that provided to other individuals"; and (iv) "exclud[ing] or otherwise deny[ing] equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association." 42 U.S.C. § 12182(b)(1)(A), (E).

105. Title III of the ADA prohibits conduct that has a disparate impact on an individual on the basis of disability, including: (i) "directly or through contractual, licensing, or other arrangements, utiliz[ing] standards or criteria or methods of administration . . . that have the effect of discriminating on the basis of disability"; and (ii) imposing "eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered." *Id.* § 12182(b)(1)(D), (b)(2)(A)(i).

106. Title III of the ADA prohibits not making "reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations." *Id.* § 12182(b)(2)(A)(ii).

107. The ADA contains a safe-harbor provision which states, among other things, that the ADA does not "prohibit or restrict . . . an insurer . . . from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law." 42 U.S.C. § 12201(c); *see also* 28 C.F.R. § 36.212. The ADA's § 12201(c) safe-harbor is limited; it "shall not be used as a subterfuge to evade the purposes of [the ADA]." 42 U.S.C. § 12201(c).

108. As insurance offices whose operations affect commerce, BCBS and MetLife are places of public accommodation under Title III of the ADA.

109. BCBS and MetLife violated Title III of the ADA by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Offering directly, or through a contractual or other arrangement with UGA and the Board, a healthcare policy that excludes treatment for gender dysphoria.

b. Offering directly, or through a contractual or other arrangement with UGA and the Board, a healthcare policy that has the effect of discriminating on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably modify the healthcare policy to include treatment for gender dysphoria.

110. The safe-harbor provision does not apply to the actions of BCBS and MetLife because there is no actuarial basis to price surgeries for gender dysphoria separately from any other type of surgery. Alternatively, the actions of BCBS and MetLife are a subterfuge to evade the purposes of the ADA.

111. As set forth above in Paragraphs 85 to 88, Mr. Musgrove has a disability, gender dysphoria, within the meaning of the ADA, as amended. *See* 28 C.F.R. § 36.105 (Title III regulations interpreting definition of disability under ADA).

112. As a result of Defendants' actions and failure to modify, Mr. Musgrove has been forced to either forego medically necessary treatment due to lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

FOURTH CAUSE OF ACTION

Unlawful Discrimination on the Basis of Disability in Violation of Section 504 of the Rehabilitation Act

Against Defendants (for compensatory damages, declaratory relief, and injunctive relief)

113. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

114. Section 504 of the Rehabilitation Act ("Section 504") provides that "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance," 29 U.S.C. § 794(a); *see* 28 C.F.R. §

42.503(a), including "discrimination in employment under any program or activity receiving Federal financial assistance," 28 C.F.R. § 42.510(a).

115. Under Section 504, a "qualified individual" means, with respect to employment, a person with a disability "who, with reasonable accommodation, can perform the essential functions of the job in question"; and, with respect to services, a person with a disability "who meets the essential eligibility requirements for the receipt of such services." 28 C.F.R. § 42.540(l).

116. Under Section 504, a "program or activity receiving Federal financial assistance" includes "a department, agency, special purpose district, or other instrumentality of a State or of a local government," "a college, university, or other postsecondary institution, or a public system of higher education," or "an entire corporation, partnership, or other private organization," which receives federal funds or "[a]ny other thing of value by way of grant, loan, contract or cooperative agreement." 29 U.S.C. § 794(b)(1); *see* 28 C.F.R. § 42.540(h).

117. Section 504 prohibits disparate treatment of a qualified individual with a disability, including, "directly or through contractual, licensing, or other arrangements": (i) "[d]eny[ing] a qualified handicapped person the opportunity accorded others to participate in the program or activity receiving Federal financial assistance"; (ii) "[d]eny[ing] a qualified handicapped person an equal opportunity to achieve the same benefits that others achieve in the program or activity receiving Federal financial assistance"; (iii) "[p]rovid[ing] different or separate assistance to handicapped persons or classes of handicapped persons than is provided to others unless such action is necessary to provide qualified handicapped persons or classes of handicapped persons with assistance as effective as that provided to others," 28 C.F.R. § 42.503(b)(1); (iv) "limit[ing], segregat[ing], or classify[ing] applicants or employees in any way that adversely affects their opportunities or status because of handicap"; and (v) "participat[ing] in a contractual or other

relationship that has the effect of subjecting qualified handicapped applicants or employees to discrimination," 28 C.F.R. § 42.510(a); *see also* 29 U.S.C. § 794(d) (stating that standards under Title I of the ADA shall apply to employment discrimination by federally-funded programs or activities).

118. Section 504 prohibits conduct that has a disparate impact on a qualified individual with a disability, including "utiliz[ing] criteria or methods of administration that either purposely or in effect discriminate on the basis of handicap" or "defeat or substantially impair accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons." 28 C.F.R. § 42.503(b)(3).

119. Section 504 prohibits not making "reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate, based on the individual assessment of the applicant or employee, that the accommodation would impose an undue hardship on the operation of its program or activity." 28 C.F.R. § 42.511(a); *see also Alexander v. Choate*, 469 U.S. 287, 301 (U.S. 1985) ("[T]o assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made [under Section 504]").

120. Because the definition of disability under the ADA and Rehabilitation Act is identical, the expanded definition of "disability" under the ADAAA, as set forth above in Paragraphs 69 to 74 applies with equal force to both statutes. *Compare* 42 U.S.C. § 12102 (defining "disability"), *with* 29 U.S.C. §§ 705(9)(B), (20)(B) (cross-referencing ADA definition of "disability"); *see also* ADAAA, *supra*, §7 (conforming Section 504's definition of "disability" to definition of disability "in section 3 of the Americans with Disabilities Act of 1990").

121. Defendants are programs or activities that receive federal financial assistance and are therefore subject to Section 504.

122. UGA and the Board violated Section 504 by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Adopting a healthcare policy that excludes treatment for gender dysphoria, and participating in a contractual or other arrangement or relationship with BCBS and MetLife that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Section 504.

b. Adopting a healthcare policy that has the effect of discrimination on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably accommodate Mr. Musgrove by modifying the healthcare policy to include treatment for gender dysphoria.

123. BCBS and MetLife violated Section 504 by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Offering a healthcare policy that excludes treatment for gender dysphoria, and participating in a contractual or other arrangement or relationship with UGA and the Board that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Section 504.

b. Offering a healthcare policy that has the effect of discrimination on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably accommodate Mr. Musgrove by modifying the healthcare policy to include treatment for gender dysphoria.

124. Mr. Musgrove is a qualified individual under Section 504 because, with respect to employment, he can perform the essential functions of his job, with or without reasonable accommodation; and, with respect to insurance services, he meets the essential eligibility requirements for the receipt of such services.

125. As set forth above in Paragraphs 85 to 88 with respect to the ADA, Mr. Musgrove has a disability, gender dysphoria, within the meaning of Section 504.[7]

126. As set forth above in Paragraphs 82 to 84 with respect to the ADA, gender dysphoria is not excluded under Section 504.[8]

127. As a result of Defendants' actions and failure to accommodate, Mr. Musgrove has been forced to either forego medically necessary treatment due to lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

[7] *See, e.g.*, *Allmond v. Akal Sec., Inc.*, 558 F.3d 1312, 1316 n. 3 (11th Cir. 2009) (stating that the Rehabilitation Act and the ADA are governed by "the same standards" and therefore may be used "interchangeably"); *Gaylor v. Georgia Dept. of Natural Resources*, 2013 WL 4790158, at *7 (N.D. Ga. 2013) ("The pleading requirements for a cause of action under Title II of the ADA and § 504 of the RA are essentially the same.").

[8] After excluding "gender identity disorders not resulting from physical impairments" from the ADA in 1990, Congress passed an identical exclusion to the Rehabilitation Act two years later. *See* 29 U.S.C. § 705 (excluding "gender identity disorders not resulting from physical impairments"); H.R. REP. NO. 102-973, at 158 (1992) (Conf. Rep.) (discussing amendment to Rehabilitation Act).

FIFTH CAUSE OF ACTION

Unlawful Discrimination on the Basis of Sex in Violation of Title VII of the Civil Rights Act of 1964
Against Defendants Board of Regents, UGA, BCBS, and MetLife
(for compensatory damages, declaratory relief, and injunctive relief)

128. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

129. Title VII provides that employers may not "discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's . . . sex." 42 U.S.C. § 2000e-2(a)(1).

130. An employer-sponsored health plan is part of the "compensation, terms, conditions, or privileges of employment." 42 U.S.C. § 2000e-2(a)(1).

131. Discrimination on the basis of external sex characteristics, brain sex, changing sex characteristics, transgender status, and nonconformity with sex- or gender-based stereotypes is discrimination on the basis of "sex" under Title VII.

132. Plaintiff is an employee of UGA as that term is defined in Title VII, 42 U.S.C. § 2000e(f).

133. UGA is an employer as that term is defined in Title VII, 42 U.S.C. § 2000e-(b). In establishing the scope of health care coverage and administering that coverage, the Board, BCBS, and MetLife are agents of UGA under Title VII.

134. BCBS unlawfully participated in discriminatory employment practices by offering a policy that contained a transgender exclusion.[9]

[9] *See U.S. Equal Employment Opportunity Commission, EEOC Compliance Manual (2000), Section 2-III-B-2(b)* (noting specifically that an insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent).

135. BCBS unlawfully participated in the discriminatory employment practices by offering to provide the Board with a discriminatory plan, contracting to provide the Board with a discriminatory health plan and denying Mr. Musgrove's requests for medical coverage.[10]

136. MetLife unlawfully participated in discriminatory employment practices by offering a policy that contained a transgender exclusion.[11]

137. MetLife unlawfully participated in the discriminatory employment practices by offering to provide the Board with a discriminatory plan, contracting to provide the Board with a discriminatory health plan and, as discussed in further detail above, offering a plan that prevented Mr. Musgrove from applying for disability coverage, denying his future requests for disability insurance coverage.[12]

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[10] *See US. Equal Employment Opportunity Commission, EEOC Compliance Manual (2000), Section 2-lll-B-2(b)* (noting specifically that an "insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent."); *Tovar v. Essentia Health*, No. 16-3186, 2017 WL 2259632, at *5 (8th Cir. May 24, 2017) (recognizing that a third party administrator can be the source of a discriminatory plan document and be held liable under Section 1557 "notwithstanding the fact that [the employer] subsequently adopted the plan and maintained control over its terms").

[11] *See U.S. Equal Employment Opportunity Commission, EEOC Compliance Manual (2000), Section 2-III-B-2(b)* (noting specifically that an insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent).

[12] *See US. Equal Employment Opportunity Commission, EEOC Compliance Manual (2000), Section 2-lll-B-2(b)* (noting specifically that an "insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent."); *Tovar v. Essentia Health*, No. 16-3186, 2017 WL 2259632, at *5 (8th Cir. May 24, 2017) (recognizing that a third party administrator can be the source of a discriminatory plan document and be held liable under Section 1557 "notwithstanding the fact that [the employer] subsequently adopted the plan and maintained control over its terms").

Discrimination *Because of* Sex

138. Just as an exclusion for all treatments of conditions that are disproportionately race- or ethnicity-based would be both race and disability discrimination, denying a class of care because it intends to change sex characteristics is literally discrimination *because of* sex.

139. Generally, all medically necessary treatment and disability leave is covered by the Health and Disability Plans. In the case of gender dysphoria, the motivation for the exclusion is rooted in sex-based concerns. The denial is stemming from a reluctance to let people change sex characteristics where the *purpose* of the treatment is to change sex characteristics. This is inherently related to and based on the patient's sex, and therefore prohibited discrimination.

Disparate Treatment of Transgender Employees

140. In 2012, the Equal Employment Opportunity Commission (EEOC) held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII." *Macy v. Dep't. of Justice*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, at *12 (Apr. 20, 2012). Furthermore, dozens of district courts—both within and outside of the circuits that have explicitly recognized sex discrimination claims by transgender people—have found that anti-transgender discrimination is unlawful sex discrimination.

141. By offering health and disability plans that explicitly exclude coverage for transgender care, the Board and UGA have made a decision to Plaintiff differently and provide him with lesser compensation and benefit options because he is transgender. The plans provide lesser coverage on their face on the basis of sex.

Disparate Impact on Transgender Employees

142. Only transgender people, people whose brain sex does not match their external sex characteristics at birth, access treatments for gender dysphoria. The sole reason these individuals access to this particular treatment is to change female characteristics into male ones and vice versa. The treatments themselves change sex characteristics.

143. The exclusion of such treatments does not impact non-transgender employees at all. They do not need access to this care and their out-of-pocket health care costs will not increase (nor will their compensation decrease) if this care is not provided. The only class of employees this exclusion impacts is transgender employees.

144. Transgender employees receive less compensation because they are not able to access medically necessary care through the insurance plan they pay into. The fact that transgender employees are not able to access medically necessary care while non-transgender employees have their medically necessary care covered evidences a disparate impact on a protected class. It impacts Plaintiff's compensation as well as his access to medical care in a way that does not affect his non-transgender co-workers.

Sex Stereotyping

145. In addition, transitioning sexes is the ultimate violation of sex stereotypes. It is assumed that people born with typical female sex characteristics are physically and mentally female and will live as women. Plaintiff, being a man who was born with typical female sex characteristics, does not conform to the stereotype that one's sex matches one's sex-based external anatomy at birth. The Board's transgender care exclusion is also therefore sex discrimination on the basis of sex stereotyping, which has long been prohibited under Title VII.

146. By excluding coverage for transgender-related care, the Board is effectively requiring Mr. Musgrove to pay the same amount as his non-transgender co-workers for insurance in exchange for less healthcare. This exclusion singles Mr. Musgrove out to receive less compensation than he would if he were not transgender, and there is no legitimate, nondiscriminatory basis for providing him with substandard benefits other than his status as someone who does not conform to the stereotypes associated with his external sex characteristics at birth. Therefore, the difference in coverage constitutes sex discrimination under Title VII.

SIXTH CAUSE OF ACTION

Unlawful Discrimination on the Basis of Sex in Violation of Title IX of the Educational Amendments of 1972
Against Defendants Board of Regents, UGA, Hull, Morehead and Elliott
(for compensatory damages, declaratory relief, and injunctive relief)

147. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

148. Under Title IX, 20 U.S.C. § 1681(a), and its implementing regulations, "[n]o person shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in employment … under any education program or activity operated by a recipient which receives Federal financial assistance." 34 C.F.R. § 106.51(a)(1) (Department of Education Title IX regulations). See also 7 C.F.R. § 15a.500(a)(1) (Department of Agriculture Title IX regulations); 45 C.F.R. § 86.51 (Department of Health and Human Services Title IX regulations).

149. Title IX's prohibition on discrimination "on the basis of sex" encompasses discrimination based on external sex characteristics, brain sex, changing sex characteristics, transgender status, and, nonconformity to sex- or gender-based stereotypes.

150. Title IX's prohibitions on sex discrimination extends to "rates of pay or other compensation," 34 C.F.R. § 106.54(a); 7 C.F.R. § 15a.500(b)(3); 45 C.F.R. § 86.54(a), and all "[f]ringe benefits available by virtue of employment, whether or not administered by the recipient," 34 C.F.R. § 106.51(b)(7); 7 C.F.R. § 15a.500(b)(7); 45 C.F.R. § 86.51(b)(7). Fringe benefits include medical, hospital or accident benefit policies or plans, and a recipient may not "[d]iscriminate on the basis of sex with regard to making fringe benefits available to employees." 34 CFR 106.56; 7 C.F.R. § 15a.525; 45 C.F.R. § 86.56. Furthermore, "[a] recipient shall not enter into any contractual or other relationship which directly or indirectly has the effect of subjecting employees or students to discrimination prohibited by this subpart, including relationships with … organizations providing or administering fringe benefits to employees of the recipient." 34 C.F.R. § 106.51(a)(3); 7 C.F.R. § 15a.500(a)(3); 45 C.F.R. § 86.51(3).

151. As federal funding recipients, Defendants UGA and the Board are subject to Title IX's prohibitions on sex- and gender-based discrimination against in employment, compensation, and fringe benefits.

152. Defendants, by adopting and enforcing a policy or practice of excluding "sex change" treatments under the Health Plan, have discriminated and continue to discriminate against Plaintiff in employment. He was and is denied the benefits of employment and excluded from full participation in the Health Plan. He receives lesser compensation than co-workers on the basis of sex because the Health Plan is less valuable to employees who require medical treatment to change sex characteristics. The existence of the "sex change" exclusion stigmatizes and demeans Plaintiff. Defendants have treated Plaintiff differently from other male and non-transgender employees based on the difference between his external sex characteristics and his brain sex, as well as his nonconformity to sex stereotypes, and thereby are denying him the full and equal participation in,

benefits of, and right to be free from discrimination in the employment-based educational opportunities offered by UGA and the Board on the basis of sex, in violation of Title IX.

153. Defendants, by adopting and enforcing a policy or practice of excluding "sex-change surgery" under the Disability Plan, have discriminated and continue to discriminate against Plaintiff in employment. He was and is denied the benefits of employment and excluded from full participation in the Disability Plan. He receives lesser compensation than co-workers on the basis of sex because the Disability Plan is less valuable to employees who require medical treatment to change sex characteristics. The existence of the "sex-change" exclusion stigmatizes and demeans Plaintiff. Defendants have treated Plaintiff differently from other male and non-transgender employees based on the difference between his external sex characteristics and his brain sex, as well as his nonconformity to sex stereotypes, and thereby are denying him the full and equal participation in, benefits of, and right to be free from discrimination in the employment-based educational opportunities offered by UGA and the Board on the basis of sex, in violation of Title IX.

154. Defendants offering even one employee benefit plan with a "sex change" exclusion stigmatizes Plaintiff on the basis of sex as well as prohibits him from enjoying the full-range of benefit choices afforded to employees who do not require surgery to change sex characteristics. Offering plans with such exclusions creates a hostile environment that denies, limits and interferes with Plaintiff's ability to participate in and benefit from his employment.

155. Plaintiff has been, and continues to be, injured by Defendants' discriminatory conduct and has suffered damages as a result.

SEVENTH CAUSE OF ACTION

Violation of 42 U.S.C. § 1983 Based on the Deprivation of Plaintiff's Rights Under the Equal Protection Clause of the Fourteenth Amendment Based on Disability
Against Defendants Hull, Morehead, and Elliott (for declaratory and injunctive relief)

156. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

157. Defendants Hull, Morehead, and Elliott are persons for purposes of 42 U.S.C. § 1983.

158. Defendants Hull, Morehead, and Elliott acting under color of state law, have violated Mr. Musgrove's rights under the Equal Protection Clause of the 14th Amendment by impermissibly discriminating against him on the basis of disability.

159. The healthcare policy adopted by Defendants Hull, Morehead, and Elliott discriminates on the basis of disability because, among other things, it excludes treatment for the medical condition of gender dysphoria.

160. Discrimination by Defendants Hull, Morehead, and Elliott is not narrowly tailored to further a compelling government interest.

161. Discrimination by Defendants Hull, Morehead, and Elliott is not substantially related to an important or exceedingly persuasive government interest.

162. Discrimination by Defendants Hull, Morehead, and Elliott is not rationally related to a legitimate government interest.

163. As a direct and proximate result of the discrimination described above and their failure to accommodate, Plaintiff has suffered injury and damages, inter alia, financial damages, mental pain and suffering, humiliation, mental anguish and emotional distress. Without injunctive relief from Defendants' discriminatory exclusion of coverage for gender dysphoria treatments,

Plaintiff will continue to suffer irreparable harm in the future, including lack of access to medical treatment.

EIGHTH CAUSE OF ACTION

Violation of 42 U.S.C. § 1983 Based on the Deprivation of Plaintiff's Rights Under the Equal Protection Clause of the Fourteenth Amendment Based on Sex

Against Defendants Hull, Morehead, and Elliott (for declaratory and injunctive relief)

164. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

165. The Equal Protection Clause of the Fourteenth Amendment to the United States Constitution prohibits the states and state actors from discriminating against individuals based on their sex.

166. Discrimination on the basis of external sex characteristics, brain sex, changing sex characteristics, transgender status, and nonconformity to sex- or gender-based stereotypes is discrimination on the basis of sex.

167. The healthcare policy adopted by Defendants Hull and Morehead discriminates on the basis of sex because, among other things: (i) the healthcare policy excludes treatments undertaken for the purpose of treating gender dysphoria, a medical condition that applies only to transgender people—i.e., those whose affirmed sex does not align with their assigned sex at birth—and therefore discriminates based on sex; and (ii) the healthcare policy excludes treatment that alters physical characteristics that—along with brain sex—comprise and define one's sex, i.e., hormone levels, genital appearance, reproductive organs, and secondary sex characteristics such as breasts.

168. Discrimination on the basis of sex is a quasi-suspect class and demands a heightened level of scrutiny.

169. As a direct and proximate result of the discrimination described above, Plaintiff has suffered injury and damages, inter alia, financial damages, mental pain and suffering, humiliation, mental anguish and emotional distress. Without injunctive relief from Defendants' discriminatory exclusion of coverage for gender dysphoria treatments, Plaintiff will continue to suffer irreparable harm in the future, including lack of access to medical treatment.

NINTH CAUSE OF ACTION

Violation of 42 U.S.C. § 1983 Based on the Deprivation of Plaintiff's Rights Under the Equal Protection Clause of the Fourteenth Amendment Based on Transgender Status
Against Defendants Hull, Morehead, and Elliott (for declaratory and injunctive relief)

170. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

171. The healthcare policy adopted by Defendants Hull and Morehead discriminates on the basis of transgender status because, among other things, it excludes treatment for the purpose of changing sex characteristics, treatment that applies only to transgender people.

172. Discrimination on the basis of transgender status is suspect and demands a heightened level of scrutiny under the United States Constitution. Defendants' actions purposefully single out a minority group (transgender people) that historically have suffered discriminatory treatment and been relegated to a position of political powerlessness solely on the basis of stereotypes and myths regarding their transgender status—a characteristic that bears no relation to their ability to contribute to society and is immutable in that it is central to their core identity.

173. As a direct and proximate result of the discrimination described above, Plaintiff has suffered injury and damages, inter alia, financial damages, mental pain and suffering, humiliation, mental anguish and emotional distress. Without injunctive relief from Defendants' discriminatory

exclusion of coverage for gender dysphoria treatments, Plaintiff will continue to suffer irreparable harm in the future, including lack of access to medical treatment.

REQUEST FOR RELIEF

WHEREFORE, Plaintiff Skyler Musgrove respectfully requests that this Court:

A. Declare that the actions of Defendants complained of herein on their face and as applied to Plaintiff violate the ADA, Section 504, Title VII, Title IX and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution;

B. Issue preliminary and permanent injunctions enjoining any further enforcement or application of the exclusion for treatments of gender dysphoria in disability or health plans and directing Defendants to provide coverage for all medically necessary pharmaceutical and surgical treatments that have been or will be sought by Plaintiff for the treatment of gender dysphoria, including health care treatments and procedures that are consistent with the applicable standards of care for gender dysphoria;

C. Award compensatory and consequential damages in an amount to be determine at trial, as permitted under the ADA, Section 504, Title VII, Title IX, in an amount that would fully compensate Plaintiff for the harm to his short- and long-term health and well-being, the emotional distress he has suffered from being denied coverage for medically necessary health care as a result of the exclusion and its application to him, his economic losses, and all other damages that have been caused by Defendants' acts and omissions alleged in this Complaint;

D. Award punitive damages for violation of Title VII;

E. Award pre-judgment and post-judgment interest at the highest lawful rate;

F. Award Plaintiffs their reasonable attorneys' fees, costs, and expenses under 42 U.S.C. § 1988 or other applicable statutes; and

G. Award Plaintiff such other and further relief as the Court may deem just and proper.

Respectfully submitted this 28th day of June, 2018.

/s/ Amanda A Farahany
Amanda A. Farahany
Georgia Bar No. 646135
Anton Sorkin*
BARRETT & FARAHANY
1100 Peachtree Street NE, Suite 500
Atlanta, Georgia 30309-4501
T: (404) 214-0120
F: (404) 214-0125
amanda@justiceatwork.com
anton@justiceatwork.com

Noah Lewis*
TRANSCEND LEGAL
3553 82nd Street, #6D
Jackson Heights, New York 11372-5148
T: (347) 612-4312
F: (347) 990-1781
nlewis@transcendlegal.org

* *Pro hac vice motion to follow*

Exhibit A

EEOC Form 161 (11/16)

U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

DISMISSAL AND NOTICE OF RIGHTS

To: **Skyler Musgrove**
[redacted]
Athens, GA 30605

From: **Atlanta District Office**
100 Alabama Street, S.W.
Suite 4R30
Atlanta, GA 30303

☐ *On behalf of person(s) aggrieved whose identity is CONFIDENTIAL (29 CFR §1601.7(a))*

EEOC Charge No.	EEOC Representative	Telephone No.
410-2018-03522	**Deidra A. Stephens, Investigator Support Asst**	**(404) 562-6868**

THE EEOC IS CLOSING ITS FILE ON THIS CHARGE FOR THE FOLLOWING REASON:

☐ The facts alleged in the charge fail to state a claim under any of the statutes enforced by the EEOC.

☐ Your allegations did not involve a disability as defined by the Americans With Disabilities Act.

☐ The Respondent employs less than the required number of employees or is not otherwise covered by the statutes.

☐ Your charge was not timely filed with EEOC; in other words, you waited too long after the date(s) of the alleged discrimination to file your charge

☒ The EEOC issues the following determination: Based upon its investigation, the EEOC is unable to conclude that the information obtained establishes violations of the statutes. This does not certify that the respondent is in compliance with the statutes. No finding is made as to any other issues that might be construed as having been raised by this charge.

☐ The EEOC has adopted the findings of the state or local fair employment practices agency that investigated this charge.

☐ Other *(briefly state)*

- NOTICE OF SUIT RIGHTS -

(See the additional information attached to this form.)

Title VII, the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, or the Age Discrimination in Employment Act: This will be the only notice of dismissal and of your right to sue that we will send you. You may file a lawsuit against the respondent(s) under federal law based on this charge in federal or state court. Your lawsuit **must be filed WITHIN 90 DAYS of your receipt of this notice**; or your right to sue based on this charge will be lost. (The time limit for filing suit based on a claim under state law may be different.)

Equal Pay Act (EPA): EPA suits must be filed in federal or state court within 2 years (3 years for willful violations) of the alleged EPA underpayment. This means that **backpay due for any violations that occurred more than 2 years (3 years) before you file suit may not be collectible.**

On behalf of the Commission

Enclosures(s)

Bernice Williams-Kimbrough,
District Director

MAR 27 2018
(Date Mailed)

cc:

Samuel C. Burch
Vice Chancellor of Legal Affairs
UNIVERSITY SYSTEM OF GEORGIA
270 Washington Street, S.W., Suite 8129
Atlanta, GA 30334

Noah E. Lewis
TRANSCEND LEGAL
3553 82nd Street, #6D
Jackson Heights, NY 11372

Exhibit B

THE CONSUMER CHOICE HSA HEALTHCARE PLAN

"Creating A More Educated Georgia"

THE UNIVERSITY SYSTEM OF GEORGIA

Consumer Choice HSA Plan Design - Effective January 1, 2017
Booklet Revised - January 2017

RESOURCE CONTACTS

Should you have questions regarding your Consumer Choice HSA healthcare plan benefits, please contact the appropriate resource(s) identified below:

For Questions About:	Please Contact	Location
Claims/Coverage Provided by the Plan For information regarding the participating providers.	Campus Human Resources/ Benefits Office Blue Cross Blue Shield of Georgia	Your Institution 1-800-424-8950 TDD/404-842-8073
BCBSGa Online Tools and Online Provider Directory	Blue Cross Blue Shield of Georgia	www.bcbsga.com or www.bcbsga.com/usg
Pre-certification for Specific Outpatient/All Inpatient Hospital Services	Blue Cross Blue Shield of Georgia	1-800-233-5765 TDD/1-800-368-4424
24/7 NurseLine For emergency room referral and for medical information from a registered nurse, 24 hours a day, 7 days a week.	Blue Cross Blue Shield of Georgia	1-888-724-2583 TDD/1-800-368-4424
Health Support Programs	Blue Cross Blue Shield of Georgia	1-800-424-8950 TDD/1-800-368-4424
Centers of Excellence Transplant Program	Blue Cross Blue Shield of Georgia	1-800-824-0581 TDD/1-800-368-4424
Behavioral Health & Substance Abuse Providers/Facilities	Blue Cross Blue Shield of Georgia	Call the number located on your identification card. 1-866-621-0554
Pharmacy Benefits	CVS/caremark	1-800-424-8950
HIPAA Coverage	Secretary	U.S. Dept. of Health and Human Services Office of Civil Rights, Region IV 61 Forsyth St. SW, Suite 3B70 Atlanta, GA 30303-8909 404-562-7886 (metro Atlanta) 1-866-627-7748 (outside of metro Atlanta)

University System of Georgia benefits website: www.usg.edu/hr/benefits.

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About Health Savings Accounts

This high deductible health plan is designed to be a federally qualified High Deductible Health Plan compatible with Health Savings Accounts. Participation in this Plan may qualify you to make a pre-tax annual contribution to a Health Savings Account (HSA). Blue Cross and Blue Shield of Georgia does NOT provide tax advice, but if you are an eligible individual, you may be able to use an HSA to take advantage of the income tax benefits available when you use money you put into the HSA to pay for qualified medical expenses that are not paid by this Plan. For more information on whether you are eligible to contribute to an HSA and the rules for such contributions, refer to the University System of Georgia's health benefits website, http://www.usg.edu/hr/benefits. Keep in mind that if you are covered by another health plan, including Medicare, you are not eligible to make new contributions to an HSA, although you may still withdraw from an existing HSA.

INTRODUCTION

This booklet (the "Benefit Booklet") describes the University System of Georgia Consumer Choice HSA Healthcare Plan (the Plan), available to employees and pre-Medicare retirees, as it is in effect as of January 1, 2017.

Your healthcare plan is designed with two important goals in mind. The primary purpose of the Plan is to provide you and your family with access to medical care in the event of an illness or serious injury. Your Consumer Choice HSA Healthcare Plan will offset member costs for Medically Necessary treatment of covered illnesses and/or injuries.

The second goal of the Plan is to encourage covered members and their families to take an active role in decisions regarding their healthcare. Your involvement begins with reading this booklet and with learning how the Consumer Choice HSA Healthcare Plan works. It is your responsibility to make efficient use of the coverage provided by the Plan. Should you have questions regarding your benefits, as presented in this booklet, please contact your campus Human Resources/Benefits Office or the appropriate vendor. Vendors are listed on the inside front cover of this plan summary document. This Benefit Booklet uses a number of capitalized terms that are defined in the "Definitions" section of this Benefit Booklet. Please refer to the Definitions section for an explanation of these terms. Also, keep in mind that this Benefit Booklet is a summary only; it does not describe every aspect of the Plan that may affect your benefits.

How to Get Language Assistance

The Plan is committed to communicating with Members about the Plan no matter what their language is. The Claims Administrator employs a language line interpretation service for use by all their Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card, and a representative will be able to help you. Translation of written materials about your benefits is also available through Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

BENEFITS AT A GLANCE

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles and Coinsurance that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs sections for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, exclusions, limitations, and terms of this Benefit Booklet including any endorsements, amendments, or riders.

To get the highest level of benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Claims Administrator will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

There is no pre-existing condition waiting period.

BENEFITS AT A GLANCE

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS *In-Network*	PLAN PROVISIONS AND BENEFITS *Out-of-Network*
Annual Deductible • Individual – In-Network and Out-of-Network are separate—they do not cross accumulate (single coverage) • Family – In-Network and Out-of-Network are separate—they do not cross accumulate (covering two or more individuals)	$2,000 $4,000	$4,000 $8,000
All services are subject to the calendar year Deductible unless otherwise specified.		
Maximum Annual Out-of-Pocket • Individual (single coverage) • Family (covering two or more individuals) Includes the Calendar Year Deductible. In-Network and Out-of-Network amounts remain separate—they do not cross accumulate.	$3,500 $7,000	$7,000 $14,000
Annual Deductibles, annual Out-of-Pocket Maximums, and annual visit limitations, will be based on a January 1 - December 31 plan year. **Member costs incurred for Balance Billing will not apply toward the annual Deductible(s) or toward the annual Out-of-Pocket Maximum (s).** **All Out-of-Network Providers used are subject to Balance Billing.**		

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS In-Network	PLAN PROVISIONS AND BENEFITS Out-of-Network
Physician Services Provided In An Office Setting		
• **Physician Office Visit** • **Specialist Office Visit** • LiveHealth Online Visit • CVS MinuteClinic	80% 80% 80% 80%	60% 60% N/A N/A
• **Preventive Care**	100%	60%
• **Laboratory Services** *(Exclusive of Wellness Care/Preventive Healthcare)* *Laboratory, X-ray, Allergy Testing, Diagnostic Tests, and Injectable Medications.* *Injectable medications that are provided in a physician's office may be covered under medical benefits.* ***Pre-certification for diagnostic testing may be required.***	80%	60%
• **Maternity Care** *(Routine Prenatal care, Delivery and Postnatal)*	80%	60%
• **Office Surgery** *Pre-certification may be required.*	80%	60%
• **Second Surgical Opinion** *(Elective Surgery)*	80%	60%
• **Allergy Testing**	80%	60%
• **Allergy Shots & Serum**	80%	60%

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS In-Network	PLAN PROVISIONSAND BENEFITS Out-of-Network
• **Treatment of TMJ** *(Temporomandibular Joint Disorders)* ***Pre-certification may be required.***	80%	60%
Inpatient Hospital Services		
Inpatient Hospital Services • **Physician Services** *Physician services may include surgery, anesthesiology, pathology, radiology and/or maternity care/delivery.* ***Pre-certification may be required.***	80% Some ***hospital-based*** Physicians (examples: emergency room physicians, anesthesiologists, pathologists, and/or radiologists) providing services may not be a part of the network even if the Hospital is In-Network. Services provided by Out-of-Network Physicians will be covered at 60% of the network rate and will be ***subject to the Out-of-Network Deductible and Balance Billing.***	60%
• **Hospital Services Other Than Those For Emergency Room Care** *Inpatient Care (Includes inpatient short term rehabilitation services)* ***Pre-certification may be required.***	80%; Limited to semi-private room	60%
• **Maternity Care**	80%	60%
• **Laboratory Services**	80%	60%

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS *In-Network*	PLAN PROVISIONS AND BENEFITS *Out-of-Network*
• **Hospice Care** ***Pre-certification is required.***	100%; ***subject to deductible.***	100%; ***subject to deductible and balance billing.***
• **Treatment of TMJ** *(Temporomandibular Joint Disorders)* ***Surgical treatment*** ***Pre-certification may be required.***	80%	60%
Outpatient Hospital/Facility Services		
• **Physician Services** ***Pre-certification may be required.***	80% Some ***hospital-based*** Physicians (examples: emergency room physicians, anesthesiologists, pathologists, and/or radiologists) providing services may not be a part of the network. Services provided by Out-of-Network Physicians will be covered at 60% of the network rate; ***subject to the Out-of-Network Deductible and balance billing.***	60%

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS In-Network	PLAN PROVISIONSAND BENEFITS Out-of-Network
• **Care in a Hospital Emergency Room (ER)** *For treatment of an emergency medical condition or injury*	80%	80%
• **Urgent Care Services**	80%	60%
• **Home Nursing Care** ***Pre-certification may be required.*** **Home Health services are limited to 120 visits per calendar year (combined in-network an out-of-network)**	80%	60%
• **Skill Nursing Facility** ***Pre-certification is required.*** **Limited to 30 days per member per plan year (combined In-Network and Out-of-Network)**	80%	60%
• **Cochlear Implants** ***Pre-certification may be required.***	80%	60%
• **Wigs (when medically necessary)**	80%	60%

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS In-Network	PLAN PROVISIONS AND BENEFITS Out-of-Network
• **Ambulance Services** *Land or air ambulance for Medically Necessary emergency transportation only.*	80%	60%
• **Durable Medical Equipment (DME)** *Rental or Purchase*	80%	60%
• **Outpatient Short Term Rehabilitation Services** **Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers – 20 visits per calendar year combined specialties for In- and Out-of-Network combined** **Speech Therapy – 20 visits per calendar year for In- and Out-of-Network combined** **Cardiac Therapy – no visit limit** **Respiratory Therapy – 30 visits per calendar year for In- and Out-of-Network combined**	80%	60%

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS In-Network	PLAN PROVISIONS AND BENEFITS Out-of-Network
Limited Medical Coverage for Dental/Oral Care • **Surgical Extraction of Impacted Teeth** *Medical benefits* ***are not*** *available for partially erupted teeth.*	80%	60%
• **Dental/Oral Care** ***Not covered; other than accidental injury to natural teeth. (Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily injury to sound natural teeth or structure occurring while a member is covered by this contract and performed within 180 days after the accident.)*** ***Please Note: Outpatient charges and anesthesia for dental services for children may be covered but will require prior approval.***	80%	60%

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS In-Network	PLAN PROVISIONS AND BENEFITS Out-of-Network
Mental Health/Substance Abuse Services ▪ Inpatient mental health and substance abuse services* (facility and physician fee)	80% of network rate	60% of network rate
Residential Treatment Center	80% of network rate	60% of network rate
▪ Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)* (facility and physician fee)	80% of network rate	60% of network rate
▪ Office mental health and substance abuse services (physician fee)	80% of network rate	60% of network rate
▪ Outpatient mental health and substance abuse services (physician fee) (*Services must be authorized by calling 1-800-292-2879. Failure to pre-certify will result in denial of benefits.)	80% of network rate	60% of network rate
Autism / Applied Behavioral Analysis (ABA) Therapy	80% of network rate	60% of network rate
Organ and Tissue Transplants *The Centers of Excellence Programs direct patients to network heart, liver, lung and bone marrow transplant specialists.* ***Prior approval may be required.***	***In-Network*:** 80% at a contracted transplant center; ***subject to deductible*** ***Out-of-Network*:** 60% of UCR (the "Usual, Customary and Reasonable" fee, as determined by the Plan Administrator) at a non-contracted transplant center; ***subject to deductible and to balance billing.*** ***There will be no donor search benefit provided if an individual uses a non-contracted transplant center.*** For additional information regarding the COE Program for organ and tissue transplants, please contact BCBSGa at 1-866-694-0724.	
Prescription Drugs: See "Pharmacy Benefit Management (PBM) Program"		

OUT OF COUNTRY
Subject to Deductible Coinsurance: 20% Note: All plan exclusions and limitations still apply.

The University System of Georgia Consumer Choice HSA Healthcare Plan does not have the legal authority to intervene when an Out-of-Network Provider Balance Bills the Member. Therefore, the Plan cannot reduce or eliminate balance billed amounts. The Plan will not make additional payments above the Plan-allowed benefit limits.

WHO CAN ENROLL

If you are employed by the University System of Georgia with a work commitment of three-quarters time (30 hours per week) or more on a regular basis, you are eligible for coverage under the Consumer Choice HSA Healthcare Plan. You must contact your Human Resources/Benefits Office and enroll online. If you are enrolling dependents, you will need to provide copies of required documentation supporting eligibility.

HOW TO ENROLL

You must complete the enrollment process for healthcare coverage. You may obtain information from your campus Human Resources/Benefits Office. The completed enrollment must include the legal names, birth dates and social security numbers of any enrolled family member.

The Plan provides four levels of coverage:

Single	Employee + One Child	Employee + Spouse	Family
Employee Only	Employee + One Child	Employee + Spouse	Employee + Two or More Dependents (Spouse and/or Children)

DEPENDENT COVERAGE

When an Employee elects ***"Employee + One Child," "Employee + Spouse," or "Family"*** coverage, his/her eligible dependents may be covered by the Plan. Eligible dependents of an Employee include:

- The Employee's legal spouse;
- The Employee's dependent child until the end of the month in which he/she attains age 26, legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee's children (or children of the Employee's Spouse) for whom the Employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the Employee for support, regardless of age. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan immediately prior to reaching age 26.

  Certification of the disability is required within 30 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically.

If you have a dependent(s) employed by the University System of Georgia, and your dependent(s) is participating in any University System of Georgia healthcare plan, you *may not* cover that dependent(s) under your *"Employee + One Child," "Employee + Spouse,"* or *"Family"* coverage.

If your spouse is employed by the University System of Georgia, but he/she does not elect to participate in an available healthcare plan, you may cover him/her under your *"Employee + Spouse"* or *"Family"* coverage.

If both a husband and wife are benefits-eligible Employees of the University System of Georgia, only one may elect to provide coverage for the other spouse and/or dependents.

WHEN EMPLOYEE COVERAGE BEGINS

As an Employee of the University System of Georgia, you have 30 days from your effective date of employment to enroll for coverage in a healthcare plan. If you enroll in this Plan within 30 days of your employment date, coverage becomes effective on the first day of the month following enrollment unless enrollment is on the first day of the month, in which case coverage becomes effective upon enrollment. For those Employees covered under an academic contract, benefits will begin on the first day of the contract if enrolled on or before that day or on the first day of the month following enrollment if they enroll after the contract start.

WHEN DEPENDENT COVERAGE BEGINS

If an eligible Dependent is enrolled in the Plan when the Employee is, under Employee + Spouse or Employee + Family coverage, the Dependent's coverage is effective at the same time that the Employee's coverage is. If a Dependent is enrolled later, the Dependent will become covered on the first of the month following his/her enrollment, except that an Employee, Spouse or child who is enrolled within 30 days of birth, adoption or placement for adoption will be covered effective as of the date of birth, adoption or placement for adoption.

You will be required to ensure that your Dependents, including newborns, are enrolled in the Plan even if you already have Employee + Family coverage. Otherwise, your Dependent will not be covered under the Plan. Contact your campus Human Resources/Benefits Office to convey all appropriate information.

ADDING OR DELETING DEPENDENTS

When you have a qualifying event, you will need to contact your campus Human Resources/Benefit Office to complete a change to add or to delete a Dependent from your coverage. Some examples of ***"qualifying events"*** include: (A) a change in employment status for you or your spouse; (B) a change in marital status; and (C) the birth or adoption of a child (including stepchildren and legally placed foster children). *There are other examples of qualifying events.*

A change must be completed with your campus Human Resources/Benefits Office within 30 days of a qualifying event; any change to your Dependent coverage must be consistent with the qualifying event, except that if you acquire a new Dependent through birth, adoption or placement for adoption, you may enroll yourself or both yourself and your spouse, as well as the new Dependent child and all eligible dependent children in the Plan if you enroll your new Dependent. If you do not exercise your right to make a change to your coverage within 30 days after the qualifying event, you may not change your coverage until the next open enrollment period.

Change of Status Upon Attainment of Age 26

Your Consumer Choice HSA Healthcare Plan will provide coverage for your Dependent until the end of the month in which he/she attains age 26. For information regarding your dependent's ability to continue healthcare coverage after he/she turns 26, please see page 66 for the section entitled, ***Your COBRA Rights***.

USG OPEN ENROLLMENT PERIOD

Open enrollment is generally held during the fall of each calendar year. Your Human Resources/Benefits Office will advise you of the specific dates for your campus open enrollment period.

Healthcare plan elections made during an open enrollment period will become effective at the beginning of a new plan year. The plan year for the University System of Georgia is currently a calendar year (January 1 – December 31).

During an open enrollment period, an active, eligible Employee may elect to: (1) enroll in a healthcare plan; (2) drop healthcare coverage; (3) participate in a different healthcare plan option; and/or (4) change his/her level of coverage (i.e. Employee Only, Employee + One Child, Employee + Spouse, or Family). Members who have COBRA coverage will have the same open enrollment period and options.

THE COST OF YOUR HEALTHCARE COVERAGE

The University System of Georgia pays a significant portion of the cost of your coverage under this Plan. Your enrollment kit will include information on the cost of this Plan as well as any other option that is available to you. Your campus Human Resources/Benefits Office will notify you of any changes in the cost to you of Plan coverage, although it is unlikely that there would be a mid-year change. Your premium depends upon the level of coverage (employee only, employee + one child, employee + spouse, or family) that you select. Active Employees (as opposed to retirees) will pay their share of the cost of coverage with pre-tax dollars.

QUALIFYING EVENTS FOR CHANGES IN HEALTHCARE PLAN COVERAGE

If you are an active Employee, your share of the cost for healthcare plan premiums is paid with pre-tax dollars. Accordingly, the Internal Revenue Services (IRS) has established strict rules regarding the operation of your healthcare plan. IRS rules state that the choices made by a covered member during an open enrollment period must remain in effect for the entire plan year (January 1 through December 31). The only exception permitted under IRS rules is when a covered member has a qualifying event.

If you have a qualifying event, you may add, change, or discontinue healthcare coverage in a manner that is consistent with that qualifying event. Appropriate documentation that verifies the occurrence of the qualifying event must be presented to your campus Human Resources/Benefits Office before a change in healthcare plan coverage will be granted or approved. Some examples of qualifying events include:

- A change in your marital status;
- The birth, adoption of a child (including stepchildren and legally placed foster children) or placement of a child for adoption;
- The death of a covered dependent;
- A change in the employment status of a covered member, his/her spouse, or his/her covered dependent(s), that affects eligibility for coverage under a cafeteria or other qualified healthcare plan;
- The loss of eligibility status by a covered dependent;
- A campus approved leave of absence without pay (maximum of 12 months);
- You and/or your spouse being called to full-time active military service/duty;
- Losing or gaining healthcare coverage eligibility under Medicare or Medicaid;

- A change in residence to a location outside of a healthcare plan's service area;

- Healthcare plan election choices made by spouses with different employers in which the employers have different healthcare plan years *(Please see the example below)*

Example:

You work for the University System of Georgia (USG) and have a January 1 – December 31 health benefits plan year. Your spouse works for XYZ employer. XYZ has an October 1 – September 30 health benefits plan year. ***Both employer health benefits plans are qualified healthcare plans.***

You have "*single"* healthcare coverage with the University System of Georgia. Your spouse, employed by XYZ, discontinues his/her healthcare coverage with XYZ effective September 30. September 30 is the end of employer XYZ's plan year. You wish to add your spouse, employed by XYZ, under your healthcare plan with the University System of Georgia, effective October 1. You request to make this change to avoid a break in healthcare coverage for your spouse.

Your spouse, employed by XYZ, conveys to XYZ that he/she will no longer participate in XYZ's healthcare plan effective October 1. Under IRS regulations, the University System of Georgia may permit you to change your election from *"single"* to *"employee + spouse"* effective October 1. The spouse, employed by XYZ, must provide documentation/certification to the USG that he/she has lost healthcare coverage with XYZ within 30 days of the qualifying event.

- The entry of a Qualified Medical Child Support Order (QMCSO)

  A court-ordered qualified medical child support order (QMCSO) results from a divorce, legal separation, annulment, or change in legal custody. A QMCSO will require that you, your spouse, former spouse or other individual provide healthcare coverage for those enrolled dependent(s) that have been approved by the court. The court order and the effective date of healthcare plan coverage for those court-designated enrolled dependent(s) must be presented to your Human Resources/Benefits Office within 90 days of the court's decision. If you are not enrolled in any level of coverage, the entry of a QMCSO will require that you enroll yourself as well as the child who is the subject of the QMCSO. There is not an option for child-only coverage.

- Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA")

  Under CHIPRA, if you or your spouse or Dependent (each, an "Eligible Individual") loses coverage under Medicaid or the Children's Health Insurance Program ("CHIP," though it is known by other names in other states; Georgia's, for example, is "PeachCare") due to the loss of eligibility for such coverage, or becomes eligible for a premium subsidy under Medicaid or CHIP, the Employee may enroll in the Plan within 60 days of the loss of coverage or within 60 days of the date that eligibility for the subsidy is determined. In either case, coverage will become effective as of the date of enrollment and will not be retroactive. The loss of eligibility for premium assistance does not give rise to a right to change coverage, so it would not permit an Employee to drop subsidized coverage outside of an open enrollment period.

PLEASE NOTE:

For each of the qualifying events identified above, you must file a ***timely*** request with your Human Resources/Benefits Office to add or to change healthcare coverage. For instances other than a qualified medical child support order (QMCSO) or a CHIPRA event, ***"timely"*** generally means ***within 30 days of the event*** that qualified you for a change in healthcare coverage (i.e., employment, loss of coverage, marriage, birth or adoption, etc.) QMCSO must be presented to your Human Resources/Benefits Office within 90 days of a court's decision, however, and you have 60 days to provide notice of a CHIPRA event.

A failure to complete a change within these time limits will prohibit you from making such changes until the next open enrollment period. Unless the change is the addition of a new Dependent via

birth, adoption or placement for adoption, the effective date for changes in healthcare coverage will be the first day of the month following the date of the receipt of the request for a change. If you acquire a new Dependent via birth, adoption or placement for adoption, however, and provide notice within 30 days, the enrollment of the new Dependent and of you, your spouse and any other eligible dependent children, if applicable, will be retroactive to the date of birth, adoption or placement for adoption.

To be "consistent with" the qualifying event, the change in your coverage generally must be only to add or drop coverage for the affected individual. For example, if you divorce, you may drop your former spouse from coverage but may not drop your own coverage. An important exception, however, is that if you acquire a new Dependent through birth, adoption or placement for adoption, you may enroll yourself, your Spouse and all eligible dependent children as well as the new dependent child.

CONTINUATION OF HEALTHCARE COVERAGE INTO RETIREMENT

A University System of Georgia Pre-65 retiree and/or Pre-65 dependents who, upon his/her separation from employment with the University System of Georgia, meets the criteria for retirement as set forth in Sections 8.2.8 and 8.2.9 (Retirement and Insurance) of **The Board of Regents Policy Manual**, may elect to continue healthcare plan coverage that he/she had immediately prior to retirement.

If you are a retiree or a dependent of a retiree and are turning age 65, your retiree health benefit will be provided in a different way. Medicare Part A and B will become your primary coverage. Your coverage through the USG group healthcare plan will end and you will enroll in supplemental healthcare coverage through the Aon Retiree Health Exchange. The USG retiree health benefit will be a contribution to a Health Reimbursement Account which may be used for reimbursement of monthly supplemental healthcare and/or prescription drug premiums and other eligible healthcare expenses.

USG RETIREE OPEN ENROLLMENT PERIOD

for Pre-65 retirees and dependents

The USG retiree open enrollment period is generally held during the fall of each calendar year and will typically coincide with the open enrollment period for active Employees.

Medicare eligible retirees and dependents age 65 and older open enrollment period will coincide with the Medicare Open Enrollment period.

A retiree will not be permitted to participate in the open enrollment period unless he/she elected to take healthcare coverage into retirement at the time of his/her separation from employment with the University System of Georgia.

PRE-65 RETIREES

During a retiree open enrollment period, an eligible Pre-65 retired employee may elect to: (1) drop or discontinue healthcare coverage; (2) participate in a different healthcare plan option; and/or (3) reduce his/her level of coverage. During the open enrollment period, a Pre-65 retiree shall not be permitted to add healthcare coverage or increase the level of coverage that he/she took into retirement. See Qualifying Events below for permitted changes to a Pre-65 retiree's healthcare plan outside of the open enrollment period.

All eligible changes made during the open enrollment period will be effective as of the next January 1.

QUALIFYING EVENTS FOR CHANGES IN RETIREE HEALTHCARE PLAN COVERAGE

A USG retiree will be permitted to make a change in the level of USG healthcare coverage that he/she took into retirement if he/she has a qualifying event. The change in retiree healthcare coverage must be consistent with the qualifying event. A retiree will be required to provide the proper documentation to justify a requested benefits coverage change to the campus Human Resources/Benefits Office from which he/she

retired. A retiree must request a coverage change within 30 days of the qualifying event.

Appropriate documentation, specific to the qualifying event, must be presented to your campus Human Resources/Benefits Office before a change in healthcare plan coverage will be granted or approved.

There are only 5 qualifying events that a University System of Georgia institution may consider in granting a change in the level of healthcare coverage for a USG Pre-65 retiree who is enrolled in one of our healthcare plans. They are:

1. Becoming eligible for Medicare due to a disability;
2. The addition of a dependent(s) because of marriage, birth, adoption or a Qualified Medical Child Support Order (QMCSO);
3. The loss of a dependent's health benefit coverage through a change in a spouse's group coverage, through COBRA coverage, through Medicare, or through Medicaid;
4. A change in a spouse's employment status that affects coverage eligibility under a qualified health plan; and
5. A CHIPRA event described below.

A Qualified Medical Child Support Order (QMCSO) is a court-ordered remedy resulting from a divorce, legal separation, annulment, or change in legal custody. A QMCSO requires that an individual provide healthcare coverage for an enrolled dependent(s) that has been approved by the court. The court order and effective date of healthcare plan coverage for a court-designated enrolled dependent(s) must be presented to the campus Human Resources/Benefits Office from which an individual retired, within 90 days of the court's decision.

You also may make a change in your level of coverage if your spouse or Dependent experiences a "CHIPRA" event. "CHIPRA" is the Children's Health Insurance Program Reauthorization Act of 2009. Under CHIPRA, if your spouse or Dependent (each, an "Eligible Individual") loses coverage under Medicaid or the Children's Health Insurance Program ("CHIP," though it is known by other names in other states; Georgia's, for example, is "PeachCare") due to the loss of eligibility for such coverage, or becomes eligible for a premium subsidy under Medicaid or CHIP, the Employee may enroll the spouse or Dependent in the Plan within 60 days of the loss of coverage or within 60 days of the date that eligibility for the subsidy is determined. In either case, coverage will become effective as of the date of enrollment and will not be retroactive. The loss of eligibility for premium assistance does not give rise to a right to change coverage, so it would not permit an Employee to drop subsidized coverage outside of an open enrollment period.

PLEASE NOTE:

For each of the qualifying events that are identified above, one must file a timely request with the Human Resources/Benefits Office from which he/she retired. For instances other than a qualified medical child support order (QMCSO), "timely" means within 30 days of the qualifying event. A QMCSO must be presented to the appropriate Human Resources/Benefits Office within 90 days of the court's decision. You have 60 days to request special enrollment after a CHIPRA event. If you acquire a new Dependent via birth, adoption or placement for adoption and provide notice within 30 days, the enrollment of your Spouse or the new Dependent will be retroactive to the date of birth, adoption or placement for adoption. Otherwise, the new enrollments are effective as of the first day of the month following your providing notice of the event.

A failure to complete a change within 30 (or 60 or 90, as applicable) days of a qualifying event will prohibit one from making such changes. Unless otherwise noted, the effective date for changes in healthcare coverage will be the first day of the month following the date of the receipt of the requested change.

PERMISSIBLE USG RETIREE HEALTHCARE PLAN CHANGES

Please be reminded that retiree healthcare premiums ***are not paid with pre-tax dollars*.** Therefore, a retiree may reduce or discontinue his/her healthcare coverage at any time during the plan year. If you wish to reduce or discontinue your healthcare coverage, please submit your request in writing to the Human Resource/Benefits Office from which you retired.

If you reduce your level of healthcare coverage, you *will not be permitted* to increase your coverage at a later date without establishing one of the qualifying events described above. ***As a retiree, if you elect to discontinue your healthcare coverage, you will not be permitted to re-enroll at a later date.***

Important Note: Effective July 1, 2015, all Pre-65 Medicare eligible retirees and dependents will have supplemental only coverage through USG Healthcare Plans

How Your Benefits Work for You

Introduction

If you have any questions about anything in this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card.

The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Deductibles and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more in out-of-pocket costs.

In-Network Services

A Member has access to primary and some specialty care directly from any In-Network Physician. A Primary Care Physicians / Providers (PCP) Referral is not needed.

When you use an In-Network Provider or get care as part of an Authorized Service (an "Authorized Service" is a special case in which an Out-of-Network Provider will be paid as an in-Network Provider), Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians/Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with the Claims Administrator to care for you.

To see a Doctor, call their office:

- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you. For services from In-Network Providers:

1. You will not be required to file any claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance and/or Deductibles that apply.) You may be billed by your In- Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Benefit Booklet.
2. Pre-certification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please refer to the "Claims Payment" section for additional information on Authorized Services.

Out-of-Network Services

When you do not use an In-Network Provider and the care is not part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and Coinsurance;
2. You may have higher cost sharing amounts (i.e., Deductibles and Coinsurance);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Pre-certification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are two ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.bcbsga.com/usg which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases, you will have to go to a lab in the Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with the Claims Administrator to help with your needs.

Please note that Blue Cross Blue Shield Healthcare Plan (BCBSHP) has several networks, and a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your Identification Card or call Customer Service to find out which network this Plan uses.

What's Covered

This section describes the Covered Services available under your Plan. Your Covered Services are subject to all the terms and conditions listed in this Benefit Booklet, including, but not limited to, Benefit Maximums, Exclusions and Medical Necessity requirements. Please read the "Benefit at a Glance" section for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also, be sure to read the "How Your Plan Works" section for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have a surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Service." As a result, you should read all the sections that might apply to your claims.

You should also know that many of the Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Please see the "Benefit at a Glance" section for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Local service to a Hospital in connection with care for a Medical Emergency or if otherwise Medically Necessary whether you are in or out of the Claims Administrator's Service Area. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance is covered subject to Medical Necessity.

Autism Services Applied Behavior Analysis (ABA)

Your Plan includes coverage for the treatment of neurological deficit disorders.

Autism Services

Your Plan includes coverage for the treatment of neurological deficit disorders, including autism. Your Plan also covers certain treatments associated with autism spectrum disorder (ASD) for dependents through age five. Coverage for ASD includes but is not limited to the following:

- Diagnosis of autism spectrum disorder;
- Treatment of autism spectrum disorder;
- Pharmacy care;
- Psychiatric care;
- Psychological care; and
- Therapeutic care.

Treatment for ASD includes Habilitative or rehabilitative services including Applied Behavior Analysis when provided or supervised by a person professionally certified by a national board of behavior analysts, or performed under the supervision of a person professionally certified by a national board of behavior analysts.

Behavioral Health Services

The Behavioral Health Services program provides benefits coverage for mental health and substance abuse treatment. The Claims Administrator provides a network of healthcare professionals and hospitals. Licensed healthcare professionals are available 24 hours a day, 7 days a week, to provide referrals for mental health and substance abuse treatment.

To access information regarding Member benefits, please contact the Claims Administrator at the number located on your identification card. A Behavioral Health Services care manager will talk with the Member, assess the Member's condition, and discuss available treatment options. The Member's care manager will guide the Member in choosing a provider from among those that participate in the network. The care manager will authorize initial treatment for the Member.

Please Note: Please contact BCBSGa at the number located on your identification card, to determine if pre- certification is required.

Inpatient Care (Behavioral Health)

If a Member is admitted to an In-Network Hospital or Facility, a care manager will authorize an initial number of days of treatment. During the Member's stay in the hospital, the care manager will review the Member's treatment plan with his/her attending physician and with his/her hospital. The care manager may authorize additional hospital/facility days if the Member's condition is deemed to be medically necessary. The criteria for establishing Medical Necessity will be determined by BCBSGa.

- In-Network Facility Charges:
  The plan will pay 80% of the network rate; subject to Deductible. Pre- certification is required.

- In-Network Provider Charges:
  The plan will pay 80% of the network rate; subject to Deductible. Pre- certification is required.

Mental health and substance abuse treatment services must be Medically Necessary and must be provided by a qualified professional. A qualified professional is a licensed Psychiatrist (MD); a licensed Clinical Psychologist (Ph.D.); a licensed Clinical Social Worker (LCSW); a licensed Professional Counselor (LPC); a licensed Marriage and Family Therapist (LMFT); and/or a Masters-level RN (Clinical Nurse Specialist).

Expenses That the Mental Health and Substance Abuse Treatment Plan does not Cover.

Some treatment/services that are not covered by the *Mental Health and Substance Abuse* Program include, but are not limited, to:

- Hypnotherapy
- Childcare, social adjustment, financial, pastoral or marriage counseling
- Psychological testing unrelated to a behavioral diagnosis
- Treatment for attention deficit disorder (ADD) or attention deficit hyper-disorder (ADHD) therapy (except diagnosis and medical management), learning disabilities, developmental delays, or speech disorders
- Educational examinations or neurolinguistical programming

- Court-ordered mental health and substance abuse treatment unless medical necessity is certified by BCBSGa
- Situational counseling other than for brief visit therapy
- Vocational or education training/services

- Treatment of a condition that arises from mental retardation, academic skills disorder, developmental disorder, or motor skills disorder

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

Benefits are available for chiropractic treatments provided by a Doctor of Chiropractic when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.

Cochlear Implants

Services for cochlear implants. The batteries for cochlear implant devices are not a Covered Service.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Removal of impacted teeth and associated hospitalization. Pre-certification is required and must be obtained by the Member from a Network Physician

- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered

Service under this Plan.

Other Dental Services

Hospital or Facility charges and anesthesia needed for dental care are covered if the Member meets any of the following conditions:

- The Member is under the age of 7;
- The Member has a chronic disability that is attributable to a mental and/ or physical impairment which results in substantial functional limitation in an area of the Member's major life activity, and the disability is likely to continue indefinitely; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Pre-certification is required for all dental services.

Diabetes Equipment, Education, and Supplies

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a health care professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "health care professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this section.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include, but are not limited to, the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)

  - Echocardiograms
  - Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

  - CT scan
  - CTA scan
  - Magnetic Resonance Imaging (MRI)
  - Magnetic Resonance Angiography (MRA)
  - Magnetic Resonance Spectroscopy (MRS)
  - Nuclear Cardiology
  - PET scans
  - PET/CT Fusion scans
  - QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See “Therapy Services” later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

  - Is meant for repeated use and is not disposable.
  - Is used for a medical purpose and is of no further use when medical need ends.
  - Is meant for use outside a medical Facility.
  - Is only for use of the patient.
  - Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by the Claims Administrator. The Plan may limit the amount of coverage for ongoing rental of equipment. The Plan may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Your Plan includes benefits for prosthetics and durable medical equipment and medical supplies for the treatment of diabetes. Your plan also includes benefits for breast pumps as described in the "Preventive Care" section.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom-made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes);
- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Wigs needed after cancer treatment and alopecia areata.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency, please call 911 or visit the nearest Hospital for treatment.

Medically Necessary Emergency Care will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you receive from an Out-of-Network Provider will be covered as an In-Network service, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance or Deductible.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls the Claims Administrator as soon as possible. The Claims Administrator will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless the Claims Administrator agrees to cover it as an Authorized Service.

Home Health Care Services

Home Health Care provides a plan for the Member's care and treatment in the home. Your coverage is outlined in the Benefits at a Glance. A visit consists of up to 4 hours of care per day. The plan consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician.

Covered Services Include:

- Visits by an RN or LPN (benefits cannot be provided for services if the nurse is related to the Member).
- Visits by a qualified physiotherapist or speech therapist or by an inhalation therapist certified by the National Board of Respiratory Therapy. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section of this Plan.

Therapy section of this Plan.

- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Administration of prescribed drugs.
- Oxygen and its administration.

Infusion Therapy

See "Therapy Services" later in this section.

Hospice Care

Hospice benefits cover Inpatient and Outpatient services for patients certified by a Physician as terminally ill with a life expectancy of 6 months or less. Also, the Physician must design and recommend a Hospice Care Program. The Physician's statement and recommended program must be pre-certified.

Covered Services include:

1. Care from an interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
3. Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
4. Social services and counseling services from a licensed social worker.
5. Nutritional support, such as intravenous feeding and feeding tubes
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
7. Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
8. Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

The Member's Doctor and Hospice medical director must certify that the Member is terminally ill and likely has less than 6 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Benefit Booklet.

In this section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

As decided by the Claims Administrator, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Prior Approval and Precertification

To maximize your benefits, you should call the Claims Administrator's Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. They will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if you are given a prior approval for

the Covered Transplant Procedure, you or your Provider must call the Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before the Plan will cover benefits for a transplant. Your Doctor must certify, and the Claims Administrator must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to the Claims Administrator as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered Members under this Plan, each will get benefits under their plan.
- When the person getting the organ is a covered Member under this Plan, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If a covered Member under this Plan is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Assistance with travel costs includes transportation to and from the Facility and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to the Claims Administrator when claims are filed. Call the Claims Administrator for complete information.

For lodging and ground transportation benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

1. Child care,
2. Mileage within the medical transplant Facility city,
3. Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator,
4. Frequent Flyer miles,
5. Coupons, Vouchers, or Travel tickets,
6. Prepayments or deposits,
7. Services for a condition that is not directly related to, or a direct result of, the transplant,
8. Phone calls,

9. Laundry,
10. Postage,
11. Entertainment,
12. Travel costs for donor companion/caregiver,
13. Return visits for the donor for a treatment of an illness found during the evaluation.
14. Meals.

Certain Human Organ and Tissue Transplant Services may be limited

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for a private room is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Claims Administrator. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother’s normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include, but not limited to:

1. Medical care visits.
2. Intensive medical care when your condition requires it.
3. Treatment for a health problem by a Doctor who is not your surgeon while you are in the

Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.

4. A personal bedside exam by a Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
5. Surgery and general anesthesia.
6. Newborn exam. A Doctor other than the one who delivered the child must do the exam.
7. Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity

Maternity Global Coverage – Maternity services are paid through global reimbursement. This reimbursement process allows a provider to only file once for all levels of maternity care (prenatal, delivery and post-natal). Any subsequent care following the initial visit for the remainder of the pregnancy will pay at 100% for the delivering doctor. If the mother changes her doctor mid-pregnancy, the global benefits will not apply towards the former doctor; only the delivering doctor. The former doctor would file all services they rendered, as global reimbursement will no longer apply.

Covered maternity services include, but are not limited to:

- Professional and Facility services for childbirth in a Facility or the home, including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Medically Necessary fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed.

Important Note about Maternity Admissions: Under federal law, the Plan may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth or less than 96 hours after a cesarean section (C-section). However, federal law does not stop the mother's or newborn's attending Provider from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, the Plan may not require a Provider to get authorization before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

Benefits include prescription oral contraceptive drugs, injectable contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Benefits are available for contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from

an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Prescription Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Nutritional Counseling

Covered Services include nutritional counseling visits when referred by your Doctor.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinion) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care Services" benefit described earlier in this Benefit Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or nurse practitioners. Services are limited to routine care and the treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and the treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in the "Urgent Care Services" later in this section.

LiveHealth Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online care visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. For Mental Health and Substance Abuse on-line Visits, see the "Mental Health and Substance Abuse" section.

Orthotics

Please refer to the "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by the Claims Administrator.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services, and
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive Care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed heath problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means the Plan covers 100% of the Maximum Allowed Amount. Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
   a. Breast cancer,
   b. Cervical cancer,
   c. Colorectal cancer,
   d. High blood pressure,
   e. Type 2 Diabetes Mellitus,

f. Cholesterol, and
g. Child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

   a. Women's contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered.
   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
   c. Gestational diabetes screening.

5. Preventive care services for tobacco cessation for members age 18 and older as recommended by the United States Preventive Services Task Force including:

   a. Counseling
   b. Prescription Drugs
   c. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

   Prescription Drugs and OTC items are limited to a no more than 180-day supply per 365 days.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

   a. Aspirin
   b. Folic acid supplement
   c. Vitamin D supplement
   d. Iron supplement

7. Bowel preparations

Please note that certain age and gender and quantity limitations apply.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites:

http://www.ahrq.gov/clinic/professionals clinicians- providers/index.html,

http://www.healthcare.gov/center/regulations/prevention.html,

http://www.cdc.gov/vaccines/recs/acip/.

Covered Services also include the following services required by state and federal law:

- Lead poisoning screening for children.
- Routine mammograms.

- Appropriate and necessary childhood immunizations that meet the standards approved by the U.S. public health service for such biological products against at least all of the following:
    - Diphtheria,
    - Pertussis,
    - Tetanus,
    - Polio,
    - Measles,
    - Mumps,
    - Rubella,
    - Hemophilus influenza b (Hib),
    - Hepatitis B, and
- Varicella (shingles).

(Additional immunizations may be covered per federal law, as indicated earlier in this section.)

- Routine colorectal cancer examination and related laboratory tests.
- Chlamydia screening.
- Ovarian surveillance testing.
- Pap smear.
- Prostate screening.

Prosthetics

Please refer to “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be considered a Covered Service, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary or you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the "Prescription Drug at a Retail or Home Delivery (Mail Order) Pharmacy" section later in this Benefit Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an inpatient or outpatient basis, including office surgeries. Covered Services include:

1. Accepted operative and cutting procedures;
2. Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
3. Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
4. Treatment of fractures and dislocations;
5. Anesthesia and surgical support when Medically Necessary; and
6. Medically Necessary pre-operative and post-operative care.

Oral Surgery

Important Note: Although this Plan provides coverage for certain oral surgeries, many types of oral surgery procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.

- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery performed to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and

- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Telemedicine

Your coverage also includes telemedicine services provided by a duly licensed Doctor or other Provider by means of audio, video, or data communications (to include secured electronic mail).

The use of standard phone, facsimile transmissions, unsecured electronic mail, or a combination thereof does not constitute telemedicine service and is not a covered benefit.

The use of telemedicine may substitute for a face-to-face "hands on" encounter for consultation.

To be eligible for payment, interactive audio and video telecommunications must be used, permitting real-time communications between the Provider and the Member. As a condition of payment, the Member must be present and participating.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness or injury. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services at spas or health clubs.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Early Intervention Services

Physical, Occupational and Speech Therapy

Benefits are available for the care and treatment of congenital defects and birth abnormalities for covered children without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. From the Member's birth until the Member's third (3rd) birthday, these early intervention services shall be provided only to the extent required by law. From the Member's birth until the Member's sixth (6th) birthday, benefits are allowed up to the maximum visits listed in the "Benefit at a Glance" for physical, speech and occupational therapies.

For all other Members (e.g. those six (6) and older, or who not qualify for the benefits above), benefits are provided only if the physical, speech or occupational therapy will result in a practical improvement in the level of functioning within a reasonable period of time and is Medically Necessary. Benefits for physical, speech or occupational are allowed up to the maximum visits listed in the "Benefit at a Glance."

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, ongoing conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy**– Nursing, durable medical equipment and Prescription Drug services that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral

Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.

- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.

- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Prescription Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See "Human Organ and Tissue Transplant" earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses and contact lenses except as listed in the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a Doctor's visit, home care visit, or at an outpatient Facility. This includes drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, injectables, and any drug that must be administered by a Provider. This section applies when your Provider orders the drug and administers it to you. Benefits for drugs that you inject or get at a Pharmacy (i.e., self- administered drugs) are not covered under this section. Benefits for those drugs are described in the "Pharmacy Benefit Manager (PBM) Program" section below or in additional materials provided by CVS/caremark, or call CVS/caremark at the number shown under the "Resource Contacts" section of this Benefit Booklet.

Important Details about Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs administered by a Provider should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before the Claims Administrator can decide if the drug is Medically Necessary. The Claims Administrator may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of its Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior Authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will contact your Provider to get the details needed to decide if Prior Authorization should be given. The Claims Administrator will give the results of its decision to both you and your Provider.

If Prior Authorization is denied, you have the right to file an Appeal (Grievance) as outlined in the "Your Right to Appeal" section of this Benefit Booklet.

For a list of Prescription Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with the Claims Administrator to verify drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of drug before the Plan will cover another. The Claims Administrator checks certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. The Claims Administrator may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. The Claims Administrator has a therapeutic drug substitutes list which is reviewed and updated from time to time. For questions or issues about therapeutic drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

1. **Acts of War, Disasters, or Nuclear Accidents –** In the event of a major disaster, epidemic, war, or other event beyond the Claims Administrator's control, the Claims Administrator will make a good faith effort to give you Covered Services. The Claims Administrator will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience. This exclusion does not apply to acts of terrorism.

2. **Administrative Charges**
   a. Charges for the completion of claim forms,
   b. Charges to get medical records or reports,
   c. Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3. **Alternative / Complementary Medicine –** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a. Acupuncture,
   b. Holistic medicine,
   c. Homeopathic medicine,
   d. Hypnosis,
   e. Aroma therapy,
   f. Massage and massage therapy,
   g. Reiki therapy,
   h. Herbal, vitamin or dietary products or therapies,
   i. Naturopathy,
   j. Thermography,
   k. Orthomolecular therapy,
   l. Contact reflex analysis,
   m. Bioenergial synchronization technique (BEST),
   n. Iridology-study of the iris,
   o. Auditory integration therapy (AIT),
   p. Colonic irrigation,
   q. Magnetic innervation therapy,
   r. Electromagnetic therapy, or
   s. Neurofeedback / Biofeedback.

4. **Before Effective Date or After Termination Date –** Charges for care you get before your coverage begins or after your coverage ends.
5. **Certain Providers -** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs

or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

6. **Charges Over the Maximum Allowed Amount –** Charges over the Maximum Allowed Amount for Covered Services.
7. **Charges Not Supported by Medical Records –** Charges for services not described in your medical records.
8. **Complications of Non-Covered Services –** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.
9. **Contraceptives –** Non-prescription contraceptive devices unless required by law.
10. **Cosmetic Services –** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or surgery to restore function of any body area that has been altered by illness or trauma.

11. **Court-Ordered Testing –** Court ordered testing or care unless Medically Necessary.
12. **Crime –** Treatment of injury or illness that results from a crime you committed or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
13. **Custodial Care –** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
14. **Dental Treatment –** Dental treatment, except as listed below.

    Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as:

    - Removing, restoring, or replacing teeth;
    - Medical care or surgery for dental problems (unless listed as a Covered Service in this Benefit Booklet);
    - Services to help dental clinical outcomes.

    Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

    This exclusion does not apply to services that must be covered by law.

15. **Dental Services –** Dental services not described as Covered Services in this Benefit Booklet.
16. **Educational Services –** Services or supplies for teaching, vocational, or self-training purposes, including Applied Behavior Analysis (ABA), except as listed in this Benefit Booklet.
17. **Experimental or Investigational Services –** Services or supplies that are found to be Experimental or Investigational. This also applies to services related to Experimental or Investigational services, whether you get them before, during, or after you get the Experimental or Investigational service or supply.

    The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Claims Administrator deems it to be Experimental or Investigational.

18. **Eyeglasses and Contact Lenses –** Eyeglasses and contact lenses to correct your eyesight.

This Exclusion does not apply to lenses needed after a covered eye surgery.

19. **Eye Exercises –** Orthoptics and vision therapy.
20. **Eye Surgery –** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
21. **Family Members –** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
22. **Foot Care –** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses, trimming nails, cleaning and preventive foot care, including but not limited to:

    a. Cleaning and soaking the feet.
    b. Applying skin creams to care for skin tone.
    c. Other services that are given when there is not an illness, injury or symptom involving the foot.

23. **Foot Orthotics –** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.
24. **Foot Surgery –** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
25. **Free Care –** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers' Compensation, and services from free clinics.

    If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

26. **Hearing Aids –** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Benefit Booklet. This Exclusion does not apply to cochlear implants.
27. **Health Club Memberships and Fitness Services –** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Provider. This Exclusion also applies to health spas.
28. **Home Care**

    a. Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a home health care Provider.
    b. Private duty nursing.
    c. Food, housing, homemaker services and home delivered meals.

29. **Infertility Treatment -** Testing or treatment related to infertility except for diagnostic services and procedures to correct an underlying medical condition. Infertility procedures not specified in this Benefit Booklet.
30. **Maintenance Therapy -** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function but does not result in any change for the better.
31. **Medical Equipment and Supplies**

    a. Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

b. Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

c. Non-Medically Necessary enhancements to standard equipment and devices.

32. **Medicare –** Services for which benefits are payable under Medicare Parts A or B, or would have been payable if you had applied for Parts A or B, except, as listed in this Benefit Booklet or as required by federal law, as described in the section titled "Medicare" in the "General Provisions" section. If you do not enroll in Medicare Part B, the Claims Administrator will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
33. **Missed or Cancelled Appointments –** Charges for missed or cancelled appointments.
34. **Non-Covered Behavioral Health Services –** Services for outpatient therapy or rehabilitation unless listed as Covered Service in this Benefit Booklet.
35. **Non-Medically Necessary Services –** Services the Claims Administrator concludes are not Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
36. **Nutritional or Dietary Supplements –** Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.
37. **Oral Surgery –** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Benefit Booklet.
38. **Outpatient Therapy or Rehabilitation –** Services for outpatient therapy or rehabilitation unless listed as a Covered Service in this Benefit Booklet.
39. **Personal Care and Convenience**

    a. Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs;

    b. First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, sterile gloves, heating pads);

    c. Home workout or therapy equipment, including treadmills and home gyms;

    d. Pools, whirlpools, spas, or hydrotherapy equipment;

    e. Hypo-allergenic pillows, mattresses, or waterbeds; or

    f. Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

40. **Private Duty Nursing –** Private Duty Nursing Services.
41. **Prosthetics –** Prosthetics for sports or cosmetic purposes.
42. **Providers –** Services you get from a non-covered provider, as defined in this Benefit Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.
43. **Routine Physical Exams –** Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, or for school activities.
44. **Sex Change –** Services and supplies for a sex change and/or the reversal of a sex change.
45. **Sexual Dysfunction –** Services or supplies for male or female sexual problems (except male organic erectile dysfunction).
46. **Stand-By Charges –** Stand-by charges of a Doctor or other Provider.
47. **Sterilization –** Reversals of elective sterilizations are not covered. This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please

see that section for further details.

48. **Surrogate Mother Services –** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
49. **Travel Costs –** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
50. **Vein Treatment –** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
51. **Vision Services –** Vision services not described as Covered Services in this Benefit Booklet.
52. **Waived Cost-shares Out-of-Network –** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
53. **Weight Loss Programs –** Programs, whether or not under medical supervision, unless listed as covered in this Benefit Booklet.

    This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

54. **Weight Loss Surgery –** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or gastroplasty (surgeries that reduce stomach size), or gastric banding procedures.

Claims Payment

This section describes how the Claims Administrator reimburses claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will still submit your claim for you, although they are not required to do so. If you submit the claim, use a claim form as described later in this section.

In order to assist you in understanding the Maximum Allowed Amount language as described below, please refer to the definition of In-Network Provider, Out-of-Network Provider and Non-Preferred Provider contained in the Definitions section of this Benefit Booklet.

Maximum Allowed Amount

General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-network Providers is based on this/your Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see "Out-of-Network Services" later in this section for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement this Plan will allow for services and supplies that:

- Meet the definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- Are Medically Necessary; and
- Are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Coinsurance. In addition, when you receive Covered Services from an Out-of-network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from an eligible Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. The application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistently with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, the Maximum Allowed Amounts may be reduced for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental

or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network or an Out-of- network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific Plan or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed to accept as reimbursement for the Covered Services. Because In- Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit www.bcbsga.com/usg.

Providers who have not signed any contract with the Claims Administrator and are not in the Claims Administrator's network for this Plan are Out-of-network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator Out-of-network fee schedule, which the Claims Administrator has established in its discretion and which the Claims Administrator reserves the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this Plan but are contracted for the Claims Administrator's indemnity product are considered Non-Preferred Providers. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount. In this case, Non-Preferred Providers may not send you a bill and collect for the amount of the Non-Preferred Provider's charge that exceeds the Maximum Allowed Amount for Covered Services.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network provider will likely result in lower out of pocket costs to you. Please

call Customer Service for help in finding an In-Network Provider or visit www.bcbsga.com/usg.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by the Claims Administrator using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible and/or Coinsurance).

Your cost share amount and Out-of-Pocket Maximums may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network or Non-Preferred Providers. Please see the "Benefit at a Glance" section in this Benefit Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

The Plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your Provider for non-covered services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding benefit caps or day/visit limits.

In some instances, you may only be asked to pay the lower In-Network cost sharing amount when you use an Out- of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by the Claims Administrator according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, the Claims Administrator must receive written notice of your claim within 12 months in order for benefits to be paid. The claim must have the information needed to determine benefits. If the claim does not include enough information, the Claims Administrator will ask for more details

and it must be sent in order for benefits to be paid, except as required by law. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information.

In certain cases, you may have some extra time to file a claim. If the Claims Administrator did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 24 months after you get Covered Services will be denied.**

Claim Forms

Contact your local Human Resources Benefits Office or Customer Service and ask for a claim form to be sent to you. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to the Plan all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), you will be responsible for any charge for services that would have been paid or reimbursed by such a program.

Payment of Benefits

The Claims Administrator may make benefit payments directly to In-Network Providers for Covered Services. If you use an Out-of-Network Provider, however, the Claims Administrator may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMCSO), as having a right to enrollment under the Plan), or that person's custodial parent or designated representative. Any benefit payments made will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to benefits to anyone else except as required by a QMCSO or any applicable state law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

Inter-Plan Programs

Out of Area services

Blue Cross Blue Shield Healthcare Plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Blue Cross Blue Shield Healthcare Plan service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Blue Cross Blue Shield Healthcare Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Blue Cross Blue Shield Healthcare Plan service area, you will obtain care from Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare Providers. Blue Cross Blue Shield Healthcare Plan payment practices in both instances are described below.

Blue Cross Blue Shield Healthcare Plan covers only limited healthcare services received outside of Blue Cross Blue Shield Healthcare Plan corporate parent's service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency and urgent care obtained outside the geographic area Blue Cross Blue

Shield Healthcare Plan corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Blue Cross Blue Shield Healthcare Plan will remain responsible for fulfilling Blue Cross Blue Shield Healthcare Plan contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside Blue Cross Blue Shield Healthcare Plan service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Blue Cross Blue Shield Healthcare Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross Blue Shield Healthcare Plan uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, your liability for any covered healthcare services would then be calculated according to applicable law. For information on states that participate in this program, go to https://www.bcbsga.com/shared/noapplication/memberservices/nosecondary/notertiary/pw_a113425.pdf.

You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area Blue Cross Blue Shield Healthcare Plan serves, if this Plan covers those healthcare

services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Blue Cross Blue Shield Healthcare Plan serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Blue Cross Blue Shield Healthcare Plan serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them that are specifically excluded from or are in excess of the limits of coverage provided by this Plan.

Non-Participating Healthcare Providers Outside The Claims Administrator's Service Area

Member Liability Calculation

When covered healthcare services are provided outside of the Claims Administrator's Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Plan would make if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Plan will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered non-network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card or go to www.bcbsga.com/usg for more information about such arrangements.

Getting Approval for Benefits

Your Plan includes the processes of Pre-certification, Predetermination and Post Service Clinical Claims Reviews to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service where they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Types of Requests

- **Prior Authorization –** Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may decide a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.
- **Pre-certification –** A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Provider must tell the Claims Administrator within 48 hours of the admission. For labor / childbirth admissions, Pre-certification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination –** An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. The Claims Administrator will check your Plan to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Plan or is Experimental or Investigational as that term is defined in this Plan.
- **Post Service Clinical Claims Review –** A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental or Investigational nature of a service, treatment or admission that did not need Pre-certification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

The Provider should contact the Claims Administrator to request a Pre-certification or Predetermination review. The Claims Administrator will work directly with the requesting Provider for the Pre-certification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

The Claims Administrator will use clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies to help make Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical polices and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time. Your Employer's Administrative Services Agreement takes precedence over these guidelines.

You are entitled to ask for and receive, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Pre-certification phone number on the back of your Identification Card.

The Claims Administrator may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management)

if in the Claims Administrator's discretion, such change furthers the provision of cost effective, value based and/or quality services.

Request Categories

- **Urgent –** A request for Pre-certification or Predetermination that, in the view of the treating Provider or any Doctor with knowledge of your medical condition, could, without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective –** A request for Pre-certification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review –** A request for Pre-certification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective –** A request for Pre-certification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Individual Case Management

The individual case management program is designed to provide benefits to eligible Members who, with their attending Physician, agree to treatment under an Alternative Benefit Plan intended to provide quality health care under lower cost alternatives. Such benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each Plan Member.

The program includes:

- the identification of potential program Members through active case-finding and referral mechanisms;
- eligibility screening;
- preparation of alternative benefit plans;
- subsequent to the approval of the parties, transfer to alternative treatment settings in which quality care will be provided.

Eligibility

A Member receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Plan benefits.

The Claims Administrator is responsible for determining eligibility for cases to be included in the program.

The Member—or legal guardian or family member, if applicable—and the attending Physician must consent to explore with the Claims Administrator the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

Benefits

Benefits will be determined on a case-specific basis, depending on the plan of treatment, and may include Covered Services under the applicable Plan.

Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is less expensive than the original treatment plan which otherwise would have been followed. The Claims Administrator will determine the maximum approved payments allowable under the Plan.

Benefits under the Plan are furnished as an alternative to other Plan benefits and are limited to the following:

- Services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Member.
- Non-structural modifications to the home which are required to meet minimum standards for safe operation of equipment.

- When necessary for the long-term care of the Member in the home-setting, respite care to relieve family members or other persons caring for the Member at home. (The respite care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. The Claims Administrator may approve, on an exception basis, up to 5 day per month of respite care when medical review of the case indicates that such action is appropriate.

The Member must obtain pre-certification from the Claims Administrator regarding the treatment plan and proposed setting to be utilized during the respite care period.

Potential cases include but are not limited to:

- spinal cord Injury;
- severe head trauma/coma;
- respiratory dependence;
- degenerative muscular/neurological disorders;
- long term IV antibiotics;
- premature birth;
- burns;
- cardiovascular accident;
- cancer;
- accidents;
- terminal illnesses;

- other cases at the Plan's discretion.

Covered Services

- Services covered under individual case management will be determined by the Plan on a case-by-case basis. Benefits may be provided for the rehabilitation of a Member on an inpatient, outpatient, or out-of- Hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.
- The program may provide or coordinate any of the types of Covered Services provided pursuant to this Benefit Booklet.

- At its sole discretion, in the context of an individual case management program, the Plan may also provide or arrange for alternative services or extra-contractual benefits which (i) are excluded by this Benefit Booklet; (ii) are neither excluded nor defined as Covered Services under this Benefit Booklet, or (iii) exceed the maximum for any Covered Service under this Benefit Booklet.

Utilization

- Benefits will be provided only when and for as long as the Plan deems they are Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long, and shall be subject to pre-certification and continuing review for Medical Necessity as set forth in such plan for treatment.
- The total benefits that may be paid will not exceed those which the Member would have otherwise have received in the absence of individual case management benefits.

Exclusions

- Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in the Claims Administrators sole discretion, significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the individual case management program.

Individual Case Management Definitions

Case Manager

The person designated by the Claims Administrator to manage and coordinate the Member's medical benefits under the individual case management program.

Provider

A Provider may be any facility or practitioner including, but not limited to Ineligible Providers, licensed or certified to give services or supplies consistent with the plan of treatment and approved by the Claims Administrator.

Termination of Individual Case Management

Services in the alternative benefit plan approved by the Claims Administrator under individual case management will cease to be Covered Services under this Plan when extra-contractual benefits or alternative services are no longer Medically Necessary, as determined by the Plan Sponsor, due to a change in the patient's condition.

Coordination of Benefits When Members Are Insured Under More Than One Plan

If a Member has healthcare coverage under another program, any other group medical expense coverage, or any local, state or governmental program (except school accident insurance coverage and Medicaid), then benefits payable under This Plan will be coordinated with the benefits payable under the other program. This Plan's liability in coordinating will not be more than 100% of the Allowable Expense or the contracted amount.

Allowable Expense means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the programs covering the Member for whom the claim is made.

Please note that several terms specific to this section are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet. For this provision only, your plan is referred to as "This Plan" and any other insurance plan as "Plan." In the rest of the Benefit Booklet, Plan has the meaning listed in the "Definitions" section.

Plan means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured, that includes continuous twenty-four
- hour coverage. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan whose benefits, by law, are in addition to those of any private insurance program or other non-governmental program.
- "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

Each contract or other arrangement for coverage above is a separate Plan. If an arrangement has two parts and these rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan/Secondary Plan The "Order of Benefit Determination Rules" below determine whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering a Member. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When there are more than two Plans covering a Member, This Plan may be a Primary Plan in relationship to one or more other Plans and may be a Secondary Plan in relationship to a different Plan or Plans.

Order of Benefit Determination Rules

When you have other coverage, claims will be paid as follows:

- Non-Dependent/Dependent

The program which covers the person as an Employee (other than as a dependent) is primary to the program which covers the person as a dependent.

- Dependent Child/Parents Not Separated or Divorced

  - For children, the healthcare plan of the parent whose birthday occurs earlier in the calendar year is deemed to be primary.
  - If both parents' birthdays occur on the same day, the healthcare plan that has insured the parent for the longest period of time is primary.
  - If one of the plans does not have the parent birthday rule, the father's healthcare plan is primary.

- Dependent Child/Parents Separated or Divorced

  a. When a *court decree has determined that one parent has financial responsibility* for medical, dental or other healthcare expenses of a child, the healthcare plan of the **parent with court- decreed financial responsibility is primary to any other plan** covering the child (regardless of which parent has custody).
  b. When a *court decree states that the parents will share joint custody*, without specifying which parent has financial responsibilities for medical or dental care expenses of a child, the plan providing primary coverage for the child will be determined as follows:

1. The healthcare plan of the parent whose birthday occurs earlier in the calendar year is primary;
   2. When both parents' birthdays occur on the same day, the healthcare plan that has insured the parent for the longest period of time is primary; and
   3. If one of the plans does not have the parent birthday rule, the father's healthcare plan is primary.

   c. In the absence of joint custody and without court-decreed financial responsibility:

1. For healthcare plans that cover a *child of separated or divorced parents who have not remarried*, the healthcare plan of the parent with custody is deemed to be primary.
   2. For healthcare plans that cover a *child of remarried parent*(s):

      - The healthcare plan of the remarried parent with custody is deemed to be primary;
      - The healthcare plan of the step-parent is deemed to be secondary; and
      - The healthcare plan of the biological parent without custody is deemed to have the third level of healthcare payment responsibility.

- Active/Inactive Employee

1. The healthcare plan that covers an insured individual as an active employee is primary over healthcare plan that covers a retiree or laid-off employee.

2. The same process is true for an active employee covered by his/her employer's group-insurance medical plan who is also covered as a dependent under a retiree's/laid-off employee's group-insurance medical plan.
3. An active employee's healthcare plan will have primary coverage responsibilities.

Facility of Payment

A payment made under another program may include an amount which should have been paid under This

Plan. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this program. This Plan will not have to pay that amount again.

Right of Reimbursement

If the amount of the payment made by This Plan is more than it should have paid under this provision, the Claims Administrator may recover the excess from one or more of:

- the persons it has paid or for whom it has paid,
- insurance companies, or
- other organizations.

Right of Reimbursement

The Plan may require reimbursement from a Member for benefits paid to or on behalf of the Member for an injury or illness involving negligence or misconduct of a third party if the Member is “made whole." A Member is made whole if the Member recovers amounts under a settlement or a judgment against a third party which is more than the sum of all economic and non-economic losses incurred as a result of an injury or illness. The amount of any reimbursement claim by the Plan will be reduced by the pro rata amount of the attorney’s fees and expenses of litigation incurred by the Member in bringing a claim against the third party. The Plan has the right to seek a declaratory judgment in court to share in the proceeds of any settlement or judgment where the Member claims he or she has not been made whole.

Any person seeking recovery from a third party on behalf of a Member for personal injury which is related to a claim for which the Plan has paid benefits must provide notice of the claim by certified mail or statutory overnight delivery to the Plan. This notice must be provided no later than 10 days prior to the consummation of any settlement or commencement of any trial. Once the notice is received, the Plan will provide a notice to the Member for any claims for reimbursement.

Voluntary Incentive Program(s)

Your Plan includes the added benefit of voluntary incentive programs. These programs are designed to encourage you to take an active role in improving your health and wellness in the areas of physical activity, nutrition, life skills such as stress management, tobacco use cessation and alternative health. A full listing of tools and program options can be found on the Claims Administrator's website at www.bcbsga.com/usg by selecting the Resources & Tools tab. Information is also available by calling Customer Service at the number on the back of your Identification Card.

How to Participate

Employees with ongoing conditions or those coping with a serious illness can call BCBSGa at 1-800-424-8950 for more information about Health Support Programs.

Programs Available

24/7 NurseLine:

Get health advice from a registered nurse, day or night.

Behavioral Health:

Support from licensed health professionals to help coordinate your care from other health providers and community resources. Get a personalized plan to help you reach your goals

Chronic Care:

Personal Health Consultants help with managing asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart disease or coronary artery disease (CAD)

Care coordination with your doctor

Personalized support helps you reach your health goals

Case Management:

A Personal Health Consultant will reach out to you after surgery, a hospital stay or if you have a serious health condition.

We'll answer your questions and go over your doctor's instructions Get help coordinating benefits for home therapy or medical supplies

End-stage renal disease (ESRD):

Your Personal Health Consultant can help you:

Schedule dialysis care and doctor visits.

Follow your treatment plan and understand your medical equipment. Find helpful resources and information.

Centers of Medical Excellence for Transplant Program

Our Centers of Medical Excellence for Transplant (CME-T) program includes both our CMEs and Blue Distinction Centers for transplant:

Get access to our transplant team.

Speak with case managers who have expertise in transplant care.

Get help in finding out about your benefits.

Get a care plan designed just for you to help you and your family.

Future Moms

Through the Future Moms prenatal care program, you'll get:

Access to talk to a Personal Health Consultant Maternity Nurse about your pregnancy, newborn care and much more.

Each future mom (and dad) has access to a Maternity Nurse during pregnancy.

A book that shows changes you can expect for you and your baby during the next nine months. Help from dietitians, pharmacists and social workers, as needed.

Neonatal Intensive Care Unit (NICU)

Our case management program for high-risk births begins by first working with members in our Future Moms maternity program:

Get a customized plan of care from a nurse with neonatal or pediatric nursing experience.

Learn how to best care for your child at home.

MyHealth Note

MyHealth Note is an educational report card on your well-being that helps you save money and stay healthy. You'll get:

A confidential, easy-to-read summary of your recent medical claims. Reminders about tests and screenings.

Tips on ways to save on health expenses.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, the Claims Administrator is committed to making sure your rights are respected while providing your health benefits. That also means giving you access to the Claims Administrator's Network Providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities: You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.

- Get the information you need to help make sure you get the most from your Health Plan, and share your feedback. This includes information on:
    - The Claims Administrator's company and services.
    - The Claims Administrator's network of doctors and other health care providers.
    - Your rights and responsibilities.
    - The rules of your health care plan.
    - The way your Health Plan works.

- Make a complaint or file an appeal about:
    - Your Plan
    - Any care you get
    - Any Covered Service or benefit ruling that your Plan makes.

    - Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician (doctor), also called a PCP, if your health care plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health

care Providers to make a treatment plan that you all agree on.

- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors or health care Providers.
- Give the Claims Administrator, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with the Plan.

- Let the Claims Administrator's customer service department know if you have any changes to your name, address or family members covered under your Plan.

The Claims Administrator is committed to providing quality benefits and customer service to its Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

Your Right to Appeal

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals (Grievances)

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records,

and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons the appeal should be processed on a more expedited basis.

All other requests for Appeals (Grievances) should be submitted in writing by the *Member* or the *Member's authorized representative*, except where the acceptance of oral *Appeals (Grievances)* is otherwise required by the nature of the *appeal* (e.g., urgent care). You or your authorized representative must submit a request for review to:

Blue Cross Blue Shield of Georgia
Post Office Box 105449
Atlanta, GA 30348-5449

You must include your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

For Out of State Appeals (Grievances)

You have to file Provider Appeals with the Host Plan. This means Providers must file Appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level Appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled “Notice of Adverse Benefit Determination.”

Voluntary Second Level Appeals (Grievances)

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary Appeals (Grievances) must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review (see below).

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal or the External Review described below before filing a lawsuit or taking other legal action of any kind against the Plan.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section.

External Review

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination. A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review. Claims submitted for External Review will be reviewed by a qualified medical professional who is not employed by the Claims Administrator or the Employer.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External

Review, you or your authorized representative must contact the Claims Administrator at the number shown on your Identification Card and provide at least the following information:

- the Member's identity;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 105449
Atlanta, GA 30348

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws.

Continuation of Coverage under Federal Law (COBRA)

A Member who loses coverage under the Plan may be able to elect to continue coverage under the Plan, at his or her own expense, for 18-36 months after coverage would otherwise end. These rights and the Member's responsibilities to protect his or her continuation rights are summarized below, but contact your Employer if you have any questions about your COBRA rights. COBRA continuation coverage is generally administered by the "COBRA Administrator," which is the office or third-party that will be your point of contact after the original qualifying event. You will receive more information on how to contact the COBRA Administrator once you have elected continuing coverage.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when a Member's coverage under the Plan would otherwise end because of certain “qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary." A qualified beneficiary is a Member who is covered under the Plan on the day before the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

Each qualified beneficiary may elect continuation independently. Members also may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a Member during the period of continuation coverage is also eligible for continuation coverage.

Initial Qualifying Event	Length of Availability of
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer’s Health Plan Due to Reduction In Hours Worked	18 months
For Spouses/ Dependents: Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer’s Health Plan Due to Reduction In Hours Worked Covered Employee’s Entitlement to Medicare (if it leads to a loss of coverage under this Plan) Divorce or Legal Separation Death of a Covered	18 months 36 months 36 months 36 months
For Dependents: Loss of Dependent Child Status, e.g., turning age 26.	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your Spouse and children can last

up to 36 months after the date of Medicare entitlement.)

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the COBRA Administrator in such a situation.

Notification Requirements

You must notify your (or the Employee's) campus Benefits/Human Resources office within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the COBRA Administrator. Thereafter, the COBRA Administrator will notify qualified beneficiaries of their rights to elect continuing coverage.

Electing COBRA Continuation Coverage

To continue enrollment, a qualified beneficiary must make an election within 60 days of the date coverage would otherwise end, or the date the COBRA Administrator notifies the qualified beneficiary of this right, whichever is later. You must pay the total premium appropriate for the type of benefit coverage you choose to continue. If the premium rate changes for active associates, your monthly premium will also change. The premium you must pay cannot be more than 102% of the total cost (Employee and Employer) of coverage available to active Employees with similar coverage, and it must be paid to the COBRA Administrator within 30 days of the date due, except that the initial premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

A qualified beneficiary who is determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, or who become disabled during the first 60 days of COBRA continuation coverage, may continue coverage for 29 months after the qualifying event. Family members of the disabled employee are also eligible for the disability extension. To qualify for the extension, the disabled qualified beneficiary must provide notice of his or her disability status within 60 days of the disability determination. In these cases, the Employer can charge 150% of premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled individual at 29 months. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the qualified beneficiary must notify the COBRA administrator of that fact in writing within 30 days after the Social Security Administration's determination.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability, and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The University System of Georgia terminates all of its group health plans.

Other Coverage Options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Continuation of Coverage Due to Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), a Member who is absent from employment on account of military leave may have a right to continuation of benefits. This right is nearly identical to COBRA except that (1) coverage is available for 24 months; and (2) the Employer pays the full premium after the first month of the absence (but not the additional 2% that is charged for COBRA continuation coverage) but pays only the active Employee rate for the first month of the absence.

Family and Medical Leave Act of 1993

An Employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An Employee who has been employed at least one year is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the Employee's child.
- The placement of a child with the Employee for the purpose of adoption or foster care.
- To care for a seriously ill Spouse, child or parent.
- A serious health condition rendering the Employee unable to perform his or her job.

If the Employee chooses to continue coverage during the leave, the Employee will be given the same health care benefits that would have been provided if the Employee were working, with the same premium contribution that applies to an active Employee. If the Employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the Employee. It will tell the Employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

Once the employee returns to work after his/her leave period ends, the Employee's coverage may be restored to the same level the Employee had prior to his/her leave period if the Employee continues to be eligible for coverage.

Please contact your Human Resources Department for more Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under this Plan is available from your campus Benefits/Human Resources office or from the COBRA Administrator.

General Provisions

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Plan or the Claims Administrator.

When Your Consumer Choice HSA Healthcare Plan Coverage Ends

Your coverage under this Plan will end on the last day of the month in which:

- You are no longer eligible to participate in the Plan;
- You elect to withdraw from the Plan during an open enrollment period (in the event of a Plan enrollment change during open enrollment, coverage will be effective January 1);
- Your employment is terminated;
- You fail to make any required employee contribution; or
- The Plan is terminated.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Benefit Booklet terms, and federal law.

Except when federal law requires the Plan to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the Plan, to the extent that payment was made for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B the Claims Administrator will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing benefits under this Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

The Claims Administrator is not responsible for the actual care you receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Claims Administrator based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

The Claims Administrator may offer pilot utilization management, care management, disease management or wellness initiatives only in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. The Claims Administrator reserves the right to discontinue a pilot initiative at any time.

Relationship of Parties (Employer-Member Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

Employer’s Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or the Provider. Except in cases of fraud, the Plan will only recover such payment during the 24 months after the date the Plan made the payment on a submitted claim. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim without regard to the length of time since the claim was paid.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. The Claims Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. The Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator may not give you notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

Worker’s Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers’

Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf to the Plan if it has made payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Benefit Booklet has a special meaning, such as Medical Necessity or Covered Services, it will start with a capital letter and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of this Plan.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed where required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Appeals (Grievance)

Please see the "Your Right to Appeal" section.

Applied Behavior Analysis (ABA)

The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that the Claims Administrator has agreed to cover at the In-Network level. You will have to pay any In-Network Deductible and/or Coinsurance that apply and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Balance Billing

The dollar amount charged by a provider that is in excess of the Plan's allowed amount for medical care or treatment. Amounts that are balance-billed by a Provider are the member's responsibility. Member costs incurred for balance billing will not apply toward the Deductible or toward the annual Out-of-Pocket Maximum.

Benefit Booklet

This document. The Benefit Booklet provides you with a summary of your benefits while you are enrolled under the Plan.

Benefit Period

Each Benefit Period begins on January 1st and ends on December 31st. If your coverage ends before the end of the calendar year, then your Benefit Period also ends.

Benefit Period Maximum

The maximum amount that the Plan will pay for specific Covered Services during a Benefit Period.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have a Center of Excellence Agreement with the Claims Administrator.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Blue Cross and Blue Shield of Georgia, Inc. was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

The percentage of a claim shown on the Benefits at a Glance section of this Benefit Booklet (80% for most In- Network Providers, for example) that is the Member's responsibility after the Deductible is satisfied and before the Out-of-Pocket Maximum has been reached.

Covered Services

Health care services, supplies, or treatment described in this Benefit Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically necessary or specifically included as a benefit under this Benefit Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental or Investigative, excluded, or limited by this Benefit Booklet or by any amendment or rider to this Benefit Booklet.
- Approved by the Claims Administrator before you get the service if Pre-certification or Prior Authorization is needed.

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in the "Termination and Continuation of Coverage" section.

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers;

is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; or (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

1. Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
2. Changing dressings of non-infected wounds, after surgery or chronic conditions,
3. Preparing meals and/or special diets,
4. Feeding by utensil, tube, or gastrostomy,
5. Common skin and nail care,
6. Supervising medicine that you can take yourself,
7. Catheter care, general colostomy or ileostomy care,
8. Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
9. Residential care and adult day care,
10. Protective and supportive care, including education,
11. Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as in a Hospital or Skilled Nursing Facility, or at home.

Deductible

A deductible is the amount that you pay for Covered Services before this Plan begins to pay. If your deductible is $1,500, for example, for services that are subject to the deductible, you will pay 100 percent of your Covered Expenses until the amount you pay reaches $1,500. After that, you share the cost with the Plan by paying Coinsurance until you have reached your Out-of-Pocket Maximum for the year.

Dependent

A Member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer

An Employer whose Employees are eligible to participate in the Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational

Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikcus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
- The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or

- It meets the following five technology assessment criteria:

    - The technology must have final approval from the appropriate government regulatory bodies.

- The scientific evidence must permit conclusions concerning the effect of the technology of health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternative.
- The technology must be beneficial in practice.

Facility

A facility including, but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by the Claims Administrator.

Health Plan or Plan

The health benefits Plan established by the Employer summarized in this Benefit Booklet, as it may be amended from time to time.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law which has:

1. Room, board and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse

9. Treatment of drug abuse

Identification Card

The latest card given to you showing your identification and group numbers, the type of coverage you have and the date coverage became effective.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with the Claims Administrator, or another organization, to give Covered Services to Members through negotiated payment arrangements.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Maximum Allowed Amount

The maximum payment that the Claims Administrator will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

The Claims Administrator reserves the right to determine whether a service or supply is Medically Necessary. The fact that a Doctor has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. The Claims Administrator considers a service Medically Necessary if it is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the Doctor, health care provider or Hospital;
- not primarily Custodial Care;
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis; and

- cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

Member

The Subscriber and his or her Dependents who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Benefit Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders

(DSM) as a mental health or substance abuse condition.

Non-Preferred Provider

A Provider who is not In-Network for this Plan but is contracted for the Claims Administrator's insured products. See "Claims Payment" and "Maximum Allowed Amount" for more details on how claims from Non-Preferred Providers are paid.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with the Claims, or the Claims Administrator's subcontractor(s), to give services to Members under this Plan.

Out-of-Pocket Maximum

The most you pay during a Benefit Period for Covered Services before your Plan begins paying benefits. The Out- of-Pocket Maximum includes your Deductible but does not include your premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Benefit at a Glance" for details.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Sponsor

The University System of Georgia, the legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Pre-certification

Please see the section "Getting Approval for Benefits" for details.

Predetermination

Please see the section “Getting Approval for Benefits” for details.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Prior Authorization

Please see the “Getting Approval for Benefits” and “Prescription Drugs Administered by a Medical Provider” sections for details.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by the Claims Administrator. Covered Providers are described throughout this Benefit Booklet. If you have a question about a Provider not described in this Benefit Booklet please call the number on the back of your Identification Card.

Referral

Please see the “How Your Plan Works” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and nurse practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by regulatory agencies.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by the Claims Administrator. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician / Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Subscriber

A person who is or was engaged in active employment with the Employer (the Employee) and is eligible for Plan coverage under the employment regulations of the Employer, including a retiree who is eligible for retiree coverage under this Plan.

Telemedicine Medical Service

A health care medical service initiated by a Doctor or provided by a health care professional, the diagnosis, treatment or consultation by a Doctor, or the transfer of medical data that requires the use of advanced communications technology other than phone or fax, including:

- Compressed digital interactive video, audio, or data transmission.
- Clinical data transmission using computer imaging by way of still-image capture; and,
- Other technology that facilitates access to healthcare services or medical specialty expertise.

Neither a telephone conversation nor an electronic mail message between a healthcare practitioner and a patient is telemedicine.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short- term medical care, without an appointment, for urgent care.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows (but does not require) the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to the Claims Administrator's website, www.bcbsga.com/usg. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to the Claims Administrator's website, www.bcbsga.com/usg.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with dollar limits or day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Coinsurance, and out of pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

Group health plans sponsored by state and local governmental employers generally must comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from some of these requirements for any part of the plan that is self-funded by the employer, rather than provided through a health insurance policy. The University System of Georgia has elected to exempt each of the University System of Georgia Healthcare Plans from the Mental Health Parity and Addiction Equity Act of 2008. This means that the Plans may impose restrictions on mental health and substance use disorders that do not apply to medical and surgical benefits covered by the Plans. This exemption will be in effect for 2017 but may be renewed for subsequent years

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your Employer or Plan Administrator provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and

- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Benefit At A Glance" for details.) If you would like more information on WHCRA benefits, call the number on the back of your Identification Card.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Customer Service telephone number on your Identification Card, or contact your Employer.

Pharmacy Benefit Management (PBM) Program

CVS/caremark is the Claims Administrator for the prescription drug benefit program for the self-insured healthcare plans of the University System of Georgia. The prescription drug benefit program was designed to offer clinical effectiveness, choice and flexibility.

Prescription Drugs (Generic, Preferred Brand, Non preferred Brand) **30-day supply (In-Network pharmacy)**	You pay 20% after Deductible is met; Plan pays 80%	You pay 20% after Deductible is met; Plan pays 80%
Prescription Drugs (Generic, Preferred Brand, Non preferred Brand) **90-day supply (Mail Order)**	You pay 20% after Deductible is met; Plan pays 80%	You pay 20% after Deductible is met; Plan pays 80%
Note: You are responsible for paying the total cost of your prescriptions until you have met your Deductible (individual or family). **If a non-participating pharmacy is used, the Member must file a claim for reimbursement; the Member may be responsible for the difference between the Maximum Allowed Amount and the amount the pharmacy charges.**		

Important Details About Prescription Drug Coverage

For specific prescribed drugs, the plan may impose certain requirements before it will cover claims for the drugs. Those requirements may include Prior Authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/tablets of medication per prescription.

Definitions

Prior Authorization – Some medications require your Provider to obtain a Prior Authorization before this Plan will cover them. The Prior Authorization process ensures that you are receiving the appropriate medications for the treatment of specific conditions and in quantities approved by the U. S. Food and Drug Administration (FDA).

Step Therapy – Several medications require you to take the covered options available for that drug before you will receive an authorization to take the original medication prescribed. Some of the medications that fall into this category are Celebrex, Solodyn, and Ximino.

Quantity Limits – Some medications have limits based on U. S. Food and Drug Administration (FDA) approved prescribing information, approved medical guidelines and/or the average utilization quantity for these medications. The limits affect only the amount of medication that the prescription benefit plan pays for, not whether you can get a greater quantity. The final decision about the amount of medication you receive remains between you and your physician. If you fill a prescription for more than the quantity limit, you are responsible for paying the additional quantity of medication beyond the set limit.

Information on medications that require Prior Authorization, step therapy and quantity limits can be found on the USG website, http://www.usg.edu/hr/benefits/pharmacy or you may contact CVS/caremark at the phone number on your ID card.

An important message for those who use specialty medications

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone, deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they are administered by a healthcare professional, self-injected, or taken orally, specialty medications require an enhanced level of service.

Conditions and therapies for which specialty medications are typically used include but are not limited to: Allergic Asthma, Cancer, Crohn's Disease, Cystic Fibrosis, Growth Hormone Disorders, Hemophilia and Bleeding Disorders, Hepatitis C, Hereditary Angioedema, Human Immunodeficiency Virus (HIV), Immune Disorders, Infertility, Lysosomal Storage Disorders, Multiple Sclerosis, Osteoporosis, Psoriasis, Pulmonary Arterial Hypertension, Respiratory Syncytial Virus (RSV), Rheumatoid Arthritis, Transplant.

For access to certain specialty medications, you may need to use CVS/caremark Specialty Pharmacy. Under your plan, some specialty medications may not be covered at your current pharmacy, or they may only be covered when ordered through CVS/caremark Specialty Pharmacy.

The CVS/caremark Specialty Pharmacy provides not only specialty medicines, but also personalized pharmacy care management services:

- Access to a team of clinical experts that are specially trained in your condition. On-call pharmacist 24 hours a day, seven days a week. Coordination of care with you and your doctor
- Convenient delivery to the address of your choice, including your doctor's office. Medicine-and condition-specific education and counseling
- Insurance and financial coordination assistance
- Online support through www.CVScaremarkSpecialtyRx.com, including condition-specific information and the specialty pharmacy drug list

To find out whether any of your specialty medications need to be ordered through CVS/caremark, please call Member Services at the toll-free number on your ID card.

What's Not Covered under Your Prescription Drug Benefit

Certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges -** Charges for the administration of any drug except for covered immunizations as approved.
2. **Clinically-Equivalent Alternatives -** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Prescription Drug, unless required by law. "Clinically equivalent" means Prescription Drugs that, for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Prescription Drug is covered and which Prescription Drugs fall into this group, please call the number on the back of your Identification Card, or visit the Claims Administrator's website at www.caremark.com. If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The other Prescription Drug will be covered only if it is Medically Necessary and appropriate over the clinically equivalent Prescription Drug. Benefits for the Prescription Drug will be reviewed from time to time to make sure the Prescription Drug is still Medically Necessary. Newly-marketed drugs are not automatically covered.
3. **Compound Drugs -** Compound drugs unless there is at least one ingredient that you need a prescription for, and the Prescription Drug is not essentially a copy of a commercially available drug product.

4. **Contrary to Approved Medical and Professional Standards -** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
5. **Delivery Charges -** Charges for delivery of Prescription Drugs.
6. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Prescription Drugs used with a diagnostic service, Prescription Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Prescription Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
7. **Drugs That Do Not Need a Prescription -** Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
8. **Drugs Over Quantity or Age Limits Prescription -** Drugs in quantities which are over the limits set by the Plan, or which are over age limits set by the Claims Administrator.
9. **Drugs Over the Quantity Prescribed or Refills After One Year -** Prescription Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original
10. **Items Covered as Durable Medical Equipment (DME) -** Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors, and contraceptive devices. Items not covered under the "Prescription Drug Benefit at a Retail or home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices, Orthotic, Prosthetics, and Medical and Surgical Supplies" benefit. Please see that section for details.
11. **Items Covered as Medical Supplies -** Oral immunizations and biologicals, even if they are federal legend Prescription Drugs, are covered as medical supplies based on where you get the service or the item. Over the counter drugs, devices or products, are not Covered Services.
12. **Items Covered as Medical Supplies -** Contraceptive devices, oral immunizations, and biologicals, even if they are federal legend Prescription Drugs, are covered as medical supplies based on where you get the service or the item. Over the counter drugs, devices or products, are not Covered Services.
13. **Items Covered Under the "Allergy Services" Benefit -** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
14. **Lost or Stolen Drugs -** Refills of lost or stolen drugs.
15. **Non-approved Drugs -** Experimental drugs are not covered.
16. **Non-formulary Drugs -** Select Non-formulary drugs are not covered.
17. **Onychomycosis Drugs -** Select drugs for Onychomycosis (toenail fungus) except when allowed to treat Members who are immunocompromised or diabetic.
18. **Sex Change Drugs -** Drugs for sex change surgery.
19. **Weight Loss Drugs -** Any drug mainly used for weight loss.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

The broad mission and extensive scope of operations of the Board of Regents of the University System of Georgia, including the constituent colleges and universities of the University System of Georgia (collectively, the "Board"), necessitates that the Board collect, maintain, and, where necessary, disseminate health information regarding the Board's students, employees, volunteers, and others. For example, the Board collects medical information through its various medical and dental hospitals, clinics, and infirmaries, through the administration of its various medical and life insurance programs, and through its various environmental health and safety programs. The Board protects the confidentiality of individually identifiable health information that is in its possession. Such health information, which is protected from unauthorized disclosure by Board policies and by state and federal law, is referred to as "protected health information," or "PHI."

PHI is defined as any individually identifiable health information regarding an employee's, a student's, or a patient's medical/dental history; mental or physical condition; or medical treatment. Examples of PHI include patient name, address, telephone and/or fax number, electronic mail address, social security number or other patient identification number, date of birth, date of treatment, medical treatment records, medical enrollment records, or medical claims records.

The Board will follow the practices that are described in its Notice of Privacy Practices ("Notice"). The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in conspicuous locations.

Permitted Uses and Disclosures of PHI

The following categories describe the different ways in which the Board may use or disclose your PHI. We include some examples that should help you better understand each category.

The Board may receive, use, or disclose your PHI to administer your health and dental benefits plan. Please be informed that the Board, under certain conditions and circumstances, may use or disclose your PHI *without obtaining your prior written authorization*. An example of this would be when the Board is required to do so by law.

For Treatment. The Board may use and disclose PHI as it relates to the provision, coordination, or management of medical treatment that you receive. The disclosure of PHI may be shared among the respective healthcare providers who are involved with your treatment and medical care. For example, if your primary care physician needs to use/disclose your PHI to a specialist, with whom he/she consults regarding your condition, this would be permitted.

For Payment. The Board may use and disclose PHI to bill and collect payment of healthcare services and items that you receive. The Board may transmit PHI to verify that you are eligible for health and /or dental benefits. The Board may be required to disclose PHI to it business associates, such as its claim processing vendor, to assist in the processing of your health and dental claims. The Board may disclose PHI to other healthcare providers and health plans for the payment of services that are rendered to you or to your covered family members by such providers or health plans.

For Healthcare Operations. The Board may use and disclose PHI as part of its business operations.

As an example, the Board may require a healthcare vendor partner (referred to as a "business associate") to survey and assess constituent satisfaction with healthcare plan design/coverage. Constituent survey results assist the Board in evaluating quality of care issues and in identifying areas for needed healthcare plan improvements. Business associates are required to agree to protect the confidentiality of your individually identifiable health information.

The Board may disclose PHI to ensure compliance with applicable laws. The Board may disclose PHI to healthcare/dental providers and health/dental plans to assist them with their required credentialing and peer review activities. The Board may disclose PHI to assist in the detection of healthcare fraud and abuse. Please be reminded that the lists of examples that are provided are not intended to be either exhaustive, or exclusive.

As Required by Law and Law Enforcement. The Board must disclose PHI when required to do so by applicable law. The Board must disclose PHI when ordered to do so in a judicial or administrative proceeding. The Board must disclose PHI to assist law enforcement personnel with the identification/location of a suspect, fugitive, material witness, or missing person. The Board must disclose PHI to comply with a law enforcement search warrant, a coroner's request for information during his/her investigation, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. The Board may disclose PHI to government agencies that are responsible for public health activities and to government agencies that are responsible for minimizing exposure to public health risks.

The Board may disclose PHI to government agencies that maintain vital records, such as births and deaths. Additional examples in which the Board may disclose PHI, as it relates to public health activities, include assisting in the prevention and control of disease; reporting incidents of child abuse or neglect; reporting incidents of abuse, neglect, or domestic violence; reporting reactions to medications or product defects; notifying an individual who may have been exposed to a communicable disease; or, notifying an individual who may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities. The Board may disclose PHI to a government agency that is authorized by law to conduct health oversight activities. Examples in which the Board may disclose PHI, as it relates to health oversight activities, include assisting with audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities that are necessary to monitor healthcare systems, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. The Board may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent; for determining a cause of death; or, otherwise as necessary, to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye, and Tissue Donation. The Board may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, the Board may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. The Board may use and disclose PHI to law enforcement personnel or other appropriate persons. The Board may use and disclose PHI to prevent or lessen a serious threat to the health or safety of a person or the public

Specialized Government Functions. The Board may use and disclose PHI for military personnel and veterans, under certain conditions, and if required by the appropriate authorities. The Board may use and disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national

security activities.

The Board may use and disclose PHI for the provision of protective services for the President of the United States, other authorized persons, or foreign heads of state. The Board may use and disclose PHI to conduct special investigations.

Workers' Compensation. The Board may disclose PHI for worker's compensation and similar programs. These programs provide benefits for work-related injuries or illnesses.

Appointment Reminders/Health Related Benefits and Services. The Board and/or its business associates may use and disclose your PHI to various other business associates that may contact you to remind you of a healthcare or dental appointment. The Board may use and disclose your PHI to business associates that will inform you of treatment program options, or, of other health related benefits/services such as Condition Care Management Programs.

Disclosures for HIPAA Compliance Investigations. The Board must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when so requested. The Secretary may make such a request of the Board to investigate its compliance with privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures of Your PHI to Which You Have an Opportunity to Object

You have the opportunity to object to certain categories of uses and disclosures of PHI that the Board may make:

Patient Directories. Unless you object, the Board may use some of your PHI to maintain a directory of individuals in its hospitals or provider facilities. This information may include your name, your location in the facility, your general condition (e.g. fair, stable, etc.), and your religious affiliation. Religious affiliation may be disclosed to members of the clergy. Except for religious affiliation, the information that is maintained in a patient directory may be disclosed to other persons who request such information by referring to your name.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, the Board may disclose your PHI to a family member, another relative, a friend, or another person whom you have identified as being involved with your healthcare, or, responsible for the payment of your healthcare. The Board may also notify these individuals concerning your location or condition.

Fundraising Activities. Unless you object, the Board may disclose your PHI to contact you for fundraising efforts to support the Board, its related foundations, and/or its cooperative organizations. Such disclosure would be limited to personal contact information, such as your name, address and telephone number. The money raised in connection with these fundraising activities would be used to expand and support the provision of healthcare and related services to the community.

If you object to the use of your PHI in any, or all, of the three instances identified above, please notify your campus or facility privacy officer, in writing.

Other Uses and Disclosures of Your PHI for Which Authorization Is Required

Certain uses and disclosures of your PHI will be made only with your written authorization. Please be advised that there are some limitations with regard to your right to object to a decision to use or disclose your PHI.

Regulatory Requirements. The Board is required, by law, to maintain the privacy of your PHI, to provide individuals with notice of the Board's legal duties and PHI privacy practices, and to abide by the terms described in this Notice.

The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise its Notice and post a new Notice in conspicuous locations. You have the following rights regarding your PHI:

You may request that the Board restrict the use and disclosure of your PHI. The Board is not required to agree to any restrictions that you request, but if the Board does so, it will be bound by the restrictions to which it agrees, except in emergency situations.

You have the right to request that communications of PHI to you from the Board be made by a particular means or at particular locations. For instance, you might request that communications be made at your work address, or by electronic mail, rather than by regular US postal mail. Your request must be made in writing. Your request must be sent to the privacy officer on your campus or facility. The Board will accommodate your reasonable requests without requiring you to provide a reason for your request.

Generally, you have the right to inspect and copy your PHI that the Board maintains, provided that you make your request in writing to the privacy officer on your campus or your facility. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. In some cases, the Board may provide you with a summary of the PHI that you request, if you agree in advance to a summary of such information and to any associated fees. If you request copies of your PHI, or agree to a summary of your PHI, the Board may impose a reasonable fee to cover copying, postage, and related costs.

If the Board denies access to your PHI, it will explain the basis for the denial. The Board will explain your opportunity to have your request and the denial reviewed by a licensed healthcare professional (who was not involved in the initial denial decision). This healthcare professional will be designated as a reviewing official. If the Board does not maintain the PHI that you request, but it knows where your requested PHI is located; it will advise you how to redirect your request.

If you believe that your PHI maintained by the Board contains an error or needs to be updated, you have the right to request that the Board correct or supplement your PHI.

Your request must be made in writing to the privacy officer on your campus or in your facility. Your written request must explain why you desire an amendment to your PHI.

Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. The Board generally can deny your request, if your request for PHI: (i) is not created by the Board, (ii) is not part of the records the Board maintains, (iii) is not subject to being inspected by you, or (iv) is accurate and complete.

If your request is denied, the Board will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial, (ii) if you do not file a statement of disagreement, to submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the Board's denial attached, and (iii) complain about the denial.

You generally have the right to request and receive a list of the disclosures of your PHI that the Board has made at any time during the six (6) years prior to the date of your request (provided that such a list would

not include disclosures made prior to April 14, 2003).

The list will not include disclosure for which you have provided a written authorization, and will not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations, (ii) made to you, (iii) for the Board's patient directory or to persons involved in your healthcare, (iv) for national security or intelligence purposes, or (v) to correctional institutions or law enforcement officials.

You should submit any such request to the privacy officer on your campus or in your facility. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will respond to you regarding the status of your request. The Board will provide the list to you at no charge. If you, however, make more than one request in a year, you will be charged a fee for each additional request. You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically. This notice may be found at the Board website address, www.usg.edu/legal/. To obtain a paper copy of this notice, please contact your campus or facility privacy officer.

You may complain to the Board if you believe your privacy rights, with respect to your PHI, have been violated by contacting the privacy officer on your campus or in your facility. You must submit a written complaint. The Board will in no manner penalize you or retaliate against you for filing a complaint regarding the Board's privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You may contact the Secretary by calling 1-866-627- 7748 (outside of metropolitan Atlanta) or (404) 562-7886 (in metropolitan Atlanta).

If you have any questions about this notice, please contact the Human Resources office on your campus or in your facility. For additional information, please contact the privacy officer on your campus or facility.

Effective Date: April 14, 2003

PLEASE NOTE:

On the following page you will find the CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION form. This form provides a spouse or another person/class of persons (organization) with the authority to act on behalf of another member. A signed authorization form provides access to PHI (protected health information) for an individual/organization other than the contract holder.

Should you need to access PHI for another individual, we ask that you photocopy this form and submit the completed form to your campus Human Resource/Benefits Office. Your campus Human Resource/Benefits Office will forward a copy to the vendor (Business Associate/Agent) associated with your request.

Should you have any questions regarding the use of this form, please contact your campus Human Resource/Benefits Office for assistance.

CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

This authorization form applies only to the release and disclosure of protected health information (PHI). This authorization is not for treatment or intended for any other purpose.

By signing this form, I authorize my college, my university, my facility, or the University System office and Business Associates/Agents to use, release, or disclose the protected health information described below to:

Name and address of person/organization to whom information may be sent:

_____ Transmit this information on or about (information will not be resent absent reauthorization):_____/_____/_____. This authorization expires upon fulfillment of this request unless special circumstances apply.

Purpose for disclosure:_

I authorize the following information to be sent to the address above:

_____Copies of all medical records for the period___/___/___to_____/___/___.

_____Copies of information described below for period___/___/___ to_____/___/___.

_____History and Physical Examination _____Lab Reports _____Reports from Physicians

_____Other (specify) _____

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted diseases (STD); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

Please include on a separate piece of paper any other special instructions or limitations.

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of my college, university, facility, or University System policies and procedures for HIPAA Compliance and any changes thereto which may be associated with this authorization. I have been provided an opportunity to discuss any concerns I may have about the use or misuse of my health information with my institutional or facility privacy officer or other appropriate personnel.

I understand that my institution or facility, the University System of Georgia, or the Board of Regents of the University System of Georgia assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release the Board of Regents of the University System of Georgia and its agents and employees from all legal liability that may arise from this authorization.

Name (please print): _____ Address:_____

Telephone: (_)_____ Group No.: _____ Member ID Number: __

Fax:)_____ Group Name:_____ Social Security Number:_____

_____

Signed:_____

Date of Birth:_____Date this Authorization Executed:_____

If the signature above is not that of the person whose medical records are authorized to be released, I am acting for the person whose medical records are being authorized for release:

My relationship to such person is:_____ Signed:_____

The person whose medical records are hereby authorized for release or that person's representative may revoke this authorization by notifying in writing the privacy officer at the person's university, college or facility. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is otherwise prohibited by the Health Insurance Portability and Accountability Act of 1996. Federal law also requires a statement that there is a potential for the protected health information released under this authorization to be subject to redisclosure by the recipient.

FORM CREATED 29 JAN 03

FUTURE OF THE PLAN

The Board of Regents of the University System of Georgia is the Plan Sponsor for the University System of Georgia Consumer Choice HSA Healthcare Plan. While the University System of Georgia expects the University System of Georgia Consumer Choice HSA Healthcare Plan to remain in effect, the University System of Georgia reserves the right to change the Plan or any benefit under the plan from time to time. The University System of Georgia also may discontinue the plan or any benefit under the plan at any time.

EMPLOYMENT RIGHTS NOT IMPLIED

Your participation in the University System of Georgia Consumer Choice HSA Healthcare Plan is not a contract of employment - it does not guarantee you continued employment with the University System of Georgia. Nor does it limit the University System of Georgia's right to discharge you, without regard to the effect that your discharge would have on your rights under the Plan. If you quit or are discharged, you have no right to future benefits from the plan except as specifically provided in this booklet and the benefit plan document.

Revised 1-15

BlueChoice®

Option

Administered by Blue Cross Blue Shield Healthcare Plan of Georgia, an Independent Licensee of the Blue Cross and Blue Shield Association

Exhibit C

YOUR BENEFIT PLAN

The Board of Regents of the University System of Georgia

All Full-Time Employees

Disability Income Insurance: Short Term Benefits and Long Term Benefits

Certificate Date: January 1, 2014

Certificate Number 1

The Board of Regents of the University System of Georgia
270 Washington St., SW
Atlanta, GA 30334

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

The Board of Regents of the University System of Georgia

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	The Board of Regents of the University System of Georgia
Group Policy Number:	307601-1-G
Type of Insurance:	Disability Income Insurance: Short Term Benefits and Long Term Benefits
MetLife Toll Free Number(s): For Claim Information	FOR DISABILITY INCOME CLAIMS: 1-800-638-2242

THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For Residents of North Dakota: If You are not satisfied with Your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of Our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if You elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under Your Certificate will not be covered.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at

1-800-638-22421-800-300-4296

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should You have a dispute concerning Your premium or about a claim, You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al numero de teléfono gratis de MetLife para información o para someter una queja al

1-800-638-22421-800-300-4296

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.

NOTICE FOR RESIDENTS OF ALL STATES

WORKERS' COMPENSATION
This certificate does not replace or affect any requirement for coverage by workers' compensation insurance.

MANDATORY DISABILITY INCOME BENEFIT LAWS
For Residents of California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico
This certificate does not affect any requirement for any government mandated temporary disability income benefits law.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1 (800) 927-4357

NOTICE FOR RESIDENTS OF CONNECTICUT

MANDATORY REHABILITATION

This certificate contains a mandatory rehabilitation provision, which may require you to participate in vocational training or physical therapy when appropriate.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DISABILITY INCOME INSURANCE

1. If Your Disability Income Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Disability Income Insurance ends because:

   - You cease to be in an Eligible Class; or
   - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Disability Income Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

NOTICE FOR RESIDENTS OF NORTH CAROLINA

Read your Certificate Carefully.

This Certificate Contains a Pre-existing Condition Limitation.

IMPORTANT CANCELLATION INFORMATION

Please Read The Provision Entitled

DATE YOUR INSURANCE ENDS

Found on Pages e/ee

NOTICE FOR RESIDENTS OF NORTH CAROLINA

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 lA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

CIVIL UNION NOTICE FOR RESIDENTS OF VERMONT

Vermont law provides that the following definitions apply to Your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.

- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.

- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.

- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

- “Civil Union” means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled “Act Relating to Civil Unions”.

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under Your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance, any person who meets the definition of “dependent” as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance.

This notice does not limit any definitions or terms included in Your certificate. It broadens definitions and terms only to the extent required by Vermont law.

DISCLOSURE:

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under “COBRA” for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine Your rights under this notice and the certificate to which it is attached.

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-877-310-6560 - toll-free
1-804-371-9691 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

Wherever the term "**Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Domestic Partner means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WEST VIRGINIA

FREE LOOK PERIOD:

If You are not satisfied with Your certificate, You may return it to Us within 10 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund within 10 days of our receipt of the returned certificate any Premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under Your certificate will not be covered.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166-0188
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS
Disability Income Insurance For You: Short Term Benefits	
Weekly Benefit…….	60.00% Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
Maximum Weekly Benefit……..	$2,500
Minimum Weekly Benefit……	$20, subject to the Overpayments and Rehabilitation Incentive subsections of this certificate.
Elimination Period……	**For Injury** • 14 calendar days of Disability. **For Sickness** • 14 calendar days of Disability.
Maximum Benefit Period……	11 weeks, excluding Your Elimination Period
Rehabilitation Incentives……	Yes
Additional Benefits:	
Organ Donor Benefit……...	Yes

SCHEDULE OF BENEFITS (continued)

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS

Disability Income Insurance For You: Long Term Benefits

Monthly Benefit……..	60.00% of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section
Maximum Monthly Benefit……	$15,000
Minimum Monthly Benefit……	$100 subject to the Overpayments and Rehabilitation Incentive subsections of this certificate.
Elimination Period……	The greater of the Short Term Disability Maximum Benefit Period or 90 Days

Maximum Benefit Period*

the later of:

- Your Normal Retirement Age;

or

- the period shown below:

Age on Date of Your Disability	Benefit Period
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

*The Maximum Benefit Period is subject to the LIMITED DISABILITY BENEFITS and DATE BENEFIT PAYMENTS END sections.

Rehabilitation Incentives……. Yes

Additional Benefits:

Monthly Payment in the Event of Your Death……. Yes

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Appropriate Care and Treatment means medical care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating Your Disability;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- consistent with a Physician's diagnosis of Your Disability; and
- intended to maximize Your medical and functional improvement.

Beneficiary means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section.

Contributory Insurance means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Disability Income Insurance: Short Term Benefits and Long Term Benefits.

Disabled or **Disability** means that, due to Sickness or as a direct result of accidental injury:

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- You are unable to earn:

- For Short Term Benefits,
  - more than 80% of Your Predisability Earnings at Your Own Occupation .

- For Long Term Benefits,
  - during the Elimination Period and the next 24 months of Sickness or accidental injury, more than 80% of Your Predisability Earnings at Your Own Occupation from any employer in Your Local Economy; and
  - after such period, more than 60% of your Predisability Earnings from any employer in Your Local Economy at any gainful occupation for which You are reasonably qualified taking into account Your training, education and experience.

For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

DEFINITIONS (continued)

If You are Disabled and have received a Monthly Benefit for 12 months, We will adjust Your Predisability Earnings only for the purposes of determining whether You continue to be Disabled and for calculating the Return to Work Incentive, if any. We will make the initial adjustment as follows:

We will add to Your Predisability Earnings an amount equal to the product of Your Predisability Earnings times 7%.

Annually thereafter, We will add an amount to Your adjusted Predisability Earnings calculated by the method set forth above but substituting Your adjusted Predisability Earnings from the prior year for Your Predisability Earnings. **This adjustment is not a cost of living benefit**.

If Your occupation requires a license, the fact that You lose Your license for any reason will not, in itself, constitute Disability.

Elimination Period means the period of Your Disability during which We do not pay benefits. The Elimination Period begins on the day You become Disabled and continues for the period shown in the SCHEDULE OF BENEFITS.

Full-Time means Active Work of at least 30 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

Local Economy means the geographic area:

- within which You reside; and
- which offers suitable employment opportunities within a reasonable travel distance.

If You move on or after the date You become Disabled, We may consider both Your former and current residence to be Your Local Economy.

Normal Retirement Age means that as defined by the federal Social Security Administration on the date Your Disability starts.

Organ Transplant Procedure means the surgical removal of any one or more of Your organs for the purpose of transplanting to another person.

Own Occupation means the essential functions You regularly perform that provide Your primary source of earned income.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);

DEFINITIONS (continued)

- siblings;
- grandparents; or
- grandchildren.

Policyholder's Retirement Plan means a plan which**:**

- provides retirement benefits to employees; and
- is funded in whole or in part by Policyholder contributions.

The term does not include:

- profit sharing plans;
- thrift or savings plans;
- non-qualified plans of deferred compensation;
- plans under IRC Section 401(k) or 457;
- individual retirement accounts (IRA);
- tax sheltered annuities (TSA) under IRC Section 403(b);
- stock ownership plans; or
- Keogh (HR-10) plans.

Predisability Earnings means gross salary or wages You were earning from the Policyholder as of Your last day of Active Work before Your Disability began. We calculate this amount on a monthly basis for Long Term Benefits and on a weekly basis for Short Term Benefits.

The term includes:

- contributions You were making through a salary reduction agreement with the Policyholder to any of the following:
  - an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
  - an executive non-qualified deferred compensation arrangement; and
  - Your fringe benefits under an IRC Section 125 plan.

The term does not include:

- commissions;
- awards and bonuses;
- overtime pay;
- the grant, award, sale, conversion and/or exercise of shares of stock or stock options;
- the Policyholder’s contributions on Your behalf to any deferred compensation arrangement or pension plan; or
- any other compensation from the Policyholder.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;

DEFINITIONS (continued)

- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Rehabilitation Program means a program that has been approved by us for the purpose of helping You return to work. It may include, but is not limited to, Your participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which You are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification/accommodation;
- training to improve job-seeking skills;
- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

Sickness means illness, disease or pregnancy, including complications of pregnancy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

We, **Us** and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time employees of the Policyholder, but not temporary or seasonal employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

For employees covered under an academic contract:

You will be eligible for insurance described in this certificate on the later of:

1. January 1, 2014; and
2. the first day of Your academic contract if You enroll on or before that date; or
3. the first day of the calendar month coincident with or next following the date You enroll if You enroll after Your academic contract start date.

For all other employees:

You will be eligible for insurance described in this certificate on the later of:

4. January 1, 2014; and
5. the first day of the calendar month coincident with or next following the date You enroll.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the process as determined by the Policyholder. If You enroll for Contributory Insurance, You must also give the Policyholder permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The insurance listed below is part of a flexible benefits plan established by the Policyholder. Subject to the rules of the flexible benefits plan and the Group Policy, You may enroll for:

- Disability Income Insurance: Long Term Benefits; and
- Disability Income Insurance: Short Term Benefits;

only when You are first eligible or during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE YOUR INSURANCE THAT IS PART OF THE FLEXIBLE BENEFITS PLAN TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 30 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible for such insurance if You are Actively at Work on that date.

If You do not complete the enrollment process within 30 days of becoming eligible, You will not be able to enroll for insurance until the next annual enrollment period, as determined by the Policyholder, following the date You first became eligible. At that time You will be able to enroll for insurance for which You are then eligible.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment During An Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The insurance enrolled for or changes to Your insurance made during an annual enrollment period will take effect on the first day of the calendar year following the annual enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day You resume Active Work.

Enrollment Due to a Qualifying Event

Under the rules of the flexible benefit plan, You may enroll for insurance for which You are eligible or change the amount of Your insurance between annual enrollment periods only if You have a Qualifying Event.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment; or
- the death of a dependent; or
- a change in Your or Your dependent Spouse's employment status, if it causes You or Your dependent Spouse to gain or lose eligibility for group coverage.

If You have a Qualifying Event, You will have 30 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance, made as a result of a Qualifying Event will take effect as follows:

- for any amount for which You are **not required** to give evidence of Your insurability, such insurance will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

- for any amount for which You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You are not Actively at Work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day You resume Active Work.

Changes in Your Disability Income Insurance will only apply to Disabilities commencing on or after the date of the change.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

for all coverages

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. the date You cease to be in an eligible class. You will cease to be in an eligible class on the last day of the calendar month in which You cease Active Work in an eligible class, if You are not disabled on that date; or
5. the last day of the calendar month in which Your employment ends; or
6. the date You retire in accordance with the last day of the calendar month in which Your employment ends.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

Reinstatement of Disability Income Insurance

If Your insurance ends, You may become insured again as follows:

1. If Your insurance ends because:

   - You cease to be in an eligible class; or
   - Your employment ends; and

   You become a member of an eligible class again within 3 months of the date Your insurance ended, You will not have to complete a new Waiting Period or provide evidence of Your insurability.

2. If Your insurance ends because you cease making the required premium while on an approved Family and Medical Leave Act (FMLA) or other legally mandated leave of absence, and you become a member of an eligible class within 31 days of the earlier of:

   - The end of the period of leave You and the Policyholder agreed upon; or
   - The end of the eligible leave period required under the FMLA or other similar legally mandated leave of absence law,

   You will not have to complete a new Waiting Period or provide evidence of Your insurability.

3. In all other cases where Your insurance ends because the required premium for Your insurance has ceased to be paid, You will be required to provide evidence of Your insurability.

If You become insured again as described in either item 1 or 2 above, the limitation for Pre-existing Conditions will be applied as if Your insurance had remained in effect with no interruption.

SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE

To prevent a loss of insurance because of a change in insurance carriers, the following rules will apply if this Disability Income Insurance replaces a plan of group disability income insurance provided to You by the Policyholder:

Prior Plan means the plan of group disability income insurance provided to You by the Policyholder through another carrier on the day before the Replacement Date.

Replacement Date means the effective date of the Disability Income Insurance under the Group Policy.

Rules for When Insurance Takes Effect if You were Insured Under the Prior Plan on the Day Before the Replacement Date:

- **If You are Actively at Work on the day before the Replacement Date**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.
- **If You are <u>not</u> Actively at Work on such date because you are Disabled,** You will become insured for Disability Income Insurance under this certificate on the Replacement Date.

  We will credit any time You accumulated toward the Elimination Period under the Prior Plan to the satisfaction of the Elimination Period required to be met under this certificate.

  Any benefits paid for such Disability will be equal to those that would have been payable to You under the Prior Plan less any amount for which the prior carrier is liable.

  Benefit payments for such Disability will end on the earliest of:

  - the date that payments end under the subsection DATE BENEFIT PAYMENTS END in this certificate; or
  - the date that payments would have ended under the provisions of the Prior Plan of Insurance.
- **If You are <u>not</u> Actively at Work on such date for any other reason,** You will become insured for Disability Income Insurance under this certificate on the date you return to Active Work.

Rules for When Insurance Takes Effect if You were <u>Not</u> Insured Under the Prior Plan on the Day Before the Replacement Date:

- You will be eligible for Disability Income Insurance under this certificate when you meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU; and
- We will credit any time You accumulated under the Prior Plan toward the eligibility waiting period under the Prior Plan to the satisfaction of the eligibility waiting period required to be met under this certificate.

Rules for Pre-existing Conditions

In determining whether a Disability is due to a Pre-existing Condition, We will credit You for any time You were insured under the Prior Plan. If Your Disability is due to a Pre-existing Condition as described in this certificate, but would not have been due to a pre-existing condition under the Prior Plan, We will pay a benefit equal to the lesser of:

- the benefit amount under this certificate; or
- the disability income insurance benefit that would have been payable to You under the Prior Plan.

If Your Disability would have been due to a pre-existing condition under the Prior Plan, it will be treated as having been caused by a Pre-existing Condition under this certificate.

Rules for Temporary Recovery from a Disability under the Prior Plan

We will waive the Elimination Period that would otherwise apply to a Disability under this certificate if You:

- received benefits for a disability that began under the Prior Plan (“Prior Plan’s disability”);
- returned to work as an active Full-Time employee prior to the Replacement Date;

SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE (continued)

- become Disabled, as defined in this certificate, after the Replacement Date and within 90 days of Your return to work due to a sickness or accidental injury that is the same as or related to the Prior Plan's disability;
- are no longer entitled to benefit payments for the Prior Plan's disability since You are no longer insured under such Plan; and
- would have been entitled to benefit payments with no further elimination period under the Prior Plan, had it remained in force.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who are not Disabled and cease Active Work in an eligible class for any of the reasons specified below.

Disability Income Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or sickness, up to 12 weeks;
2.. if You cease Active Work due to any other Policyholder approved leave of absence, check with the Policyholder to determine if Your insurance can be continued and for how long.

The Policyholder's general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

EVIDENCE OF INSURABILITY

We require evidence of insurability satisfactory to Us as follows:

1. if You make a late request for Disability Income Insurance: Short Term Benefits. A late request is one made after You were first eligible to enroll for Disability Income Insurance: Short Term Benefits.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Disability Income Insurance: Short Term Benefits.

The evidence of insurability is to be given at Your expense.

DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Weekly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to the Date Benefit Payments End section.

To verify that You continue to be Disabled without interruption after Our initial approval of the Disability claim, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews, or functional capacity exams, as needed.

While You are Disabled, the Weekly Benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

BENEFIT PAYMENT

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Weekly Benefit one week after the date benefits begin to accrue. We will make subsequent payments weekly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each week. For any partial week of Disability, payment will be made at the daily rate of 1/5th of the Weekly Benefit payable.

We will pay Weekly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

While You are receiving Weekly Benefits, You will be required to continue to pay for the cost of any disability income insurance defined as Contributory Insurance.

RECOVERY FROM A DISABILITY

For purposes of this subsection, the term Active Work only includes those days You actually work.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group short term disability plan.

If You Return to Active Work Before Completing Your Elimination Period

If You return to Active Work before completing Your Elimination Period and then become Disabled, You will have to complete a new Elimination Period.

If You Return to Active Work After Completing Your Elimination Period

If You return to Active Work after You begin to receive Weekly Benefits, We will consider You to have recovered from Your Disability.

If You return to Active Work for a period of 30 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS (continued)

REHABILITATION INCENTIVES

Rehabilitation Program Incentive

If You participate in a Rehabilitation Program, We will increase Your Weekly Benefit by an amount equal to 10% of the Weekly Benefit. We will do so before We reduce Your Weekly Benefit by any Other Income.

Work Incentive

If You work while You are Disabled and receiving Weekly Benefits, Your Weekly Benefit will be adjusted as follows:

- Your Weekly Benefit will be increased by Your Rehabilitation Program Incentive, if any; and
- reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Weekly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Weekly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability.

In addition, the Minimum Weekly Benefit will not apply.

Family Care Incentive

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to $100 for weekly expenses You incur for each family member to provide:

- care for Your or Your spouse's child, legally adopted child, or child for whom You or Your Spouse are legal guardian and who is:
  - living with You as part of Your household;
  - dependent on You for support; and
  - under age 13.

  The child care must be provided by a licensed child care provider who may not be a member of Your immediate family or living in Your residence.

- care to Your family member who is:
  - living with You as part of Your household;
  - chiefly dependent on You for support; and
  - incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to Your family member may not be provided by a member of Your immediate family.

We will make reimbursement payments to You on a weekly basis starting with the 4th Weekly Benefit payment. Payments will not be made beyond the Maximum Benefit Period. We will not reimburse You for any expenses for which You are eligible for payment from any other source. You must send Proof that You have incurred such expenses.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Monthly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to the DATE BENEFIT PAYMENTS END section.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

While You are Disabled, the Monthly Benefit described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

BENEFIT PAYMENT

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Monthly Benefit on the date which occurs on the first day of the month after the date benefits begin to accrue. We will make subsequent payments monthly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each month.

We will pay Monthly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

While You are receiving Monthly Benefits, You will not be required to pay premiums for the cost of any disability income insurance defined as Contributory Insurance.

RECOVERY FROM A DISABILITY

If You return to Active Work, We will consider You to have recovered from Your Disability.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group long term disability plan.

If You Return to Active Work Before Completing Your Elimination Period

If You return to Active Work before completing Your Elimination Period for a period of 30 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 30 days, and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work only includes those days You actually work.

If You Return to Active Work After Completing Your Elimination Period

If You return to Active Work after completing Your Elimination Period for a period of 180 calendar days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)

If You return to Active Work for a period of more than 180 calendar days and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work includes all of the continuous days which follow Your return to work for which You are not Disabled.

REHABILITATION INCENTIVES

Rehabilitation Program Incentive

If You participate in a Rehabilitation Program, We will increase Your Monthly Benefit by an amount equal to 10% of the Monthly Benefit. We will do so before We reduce Your Monthly Benefit by any other income.

Work Incentive

While You are Disabled, We encourage You to work. If You work while You are Disabled and receiving Monthly Benefits, Your Monthly Benefit will be adjusted as follows:

- Your Monthly Benefit will be increased by Your Rehabilitation Program Incentive, if any; and
- reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Monthly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Monthly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability.

In addition, the Minimum Monthly Benefit will not apply.

Limit on Work Incentive

After the first 24 months following Your Elimination Period, We will reduce Your Monthly Benefit by 50% of the amount You earn from working while Disabled.

Family Care Incentive

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to $400 for monthly expenses You incur for each family member to provide:

- care for Your or Your Spouse's child, legally adopted child, or child for whom You or Your Spouse are legal guardian and who is:
  - living with You as part of Your household;
  - dependent on You for support; and
  - under age 13.

  The child care must be provided by a licensed child care provider who may not be a member of Your immediate family or living in Your residence.

- care to Your family member who is:
  - living with You as part of Your household;
  - chiefly dependent on You for support; and
  - incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to Your family member may not be provided by a member of Your immediate family.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)

We will make reimbursement payments to You on a monthly basis starting with the first Monthly Benefit payment until You have received 24 Monthly Benefit Payments. Payments will not be made beyond the Maximum Benefit Period. We will not reimburse You for any expenses for which You are eligible for payment from any other source. You must send Proof that You have incurred such expenses.

DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT

We will reduce Your Disability benefit by the amount of all Other Income. Other Income includes the following:

1. any disability or retirement benefits which You receive because of Your disability or retirement under:
   - Railroad Retirement Act;
   - any state or public employee retirement or disability plan; or
   - any pension or disability plan of any other nation or political subdivision thereof.
2. any income received for disability or retirement under the Policyholder's Retirement Plan, to the extent that it can be attributed to the Policyholder's contributions;
3. any income received for disability under:
   - a group insurance policy to which the Policyholder has made a contribution, such as:
     - benefits for loss of time from work due to disability;
     - installment payments for permanent total disability;
   - a no-fault auto law for loss of income, excluding supplemental disability benefits;
   - a government compulsory benefit plan or program which provides payment for loss of time from Your job due to Your disability, whether such payment is made directly by the plan or program, or through a third party;
   - a self-funded plan, or other arrangement if the Policyholder contributes toward it or makes payroll deductions for it;
   - workers' compensation or a similar law which provides periodic benefits;
   - occupational disease laws;
   - laws providing for maritime maintenance and cure;
   - unemployment insurance law or program; and
   - any income that You receive from working while Disabled to the extent that such income reduces the amount of Your Weekly Benefit as described in REHABILITATION INCENTIVES. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source; and
   - recovery amounts that You receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings.

SINGLE SUM PAYMENT

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If We adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)

If You receive Other Income in the form of a single sum payment and We do not receive the Written Proof described above within 10 days after You receive the single sum payment, We will adjust the amount of Your Disability Benefit by the amount of such payment.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT

We will reduce Your Disability benefit by the amount of all Other Income. Other Income includes the following:

1. any disability or retirement benefits which You, Your Spouse or child(ren) receive or are eligible to receive because of Your disability or retirement under:
   - Federal Social Security Act;
   - Railroad Retirement Act;
   - any state or public employee retirement or disability plan; or
   - any pension or disability plan of any other nation or political subdivision thereof.
2. any income received for disability or retirement under the Policyholder's Retirement Plan, to the extent that it can be attributed to the Policyholder's contributions.
3. any income received for disability under:
   - a group insurance policy to which the Policyholder has made a contribution, such as:
     - benefits for loss of time from work due to disability;
     - installment payments for permanent total disability;
   - a no-fault auto law for loss of income, excluding supplemental disability benefits;
   - a government compulsory benefit plan or program which provides payment for loss of time from Your job due to Your disability, whether such payment is made directly by the plan or program, or through a third party;
   - a self-funded plan, or other arrangement if the Policyholder contributes toward it or makes payroll deductions for it;
   - workers' compensation or a similar law which provides periodic benefits;
   - occupational disease laws;
   - laws providing for maritime maintenance and cure;
   - unemployment insurance law or program;
4. any income that You receive from working while Disabled to the extent that such income reduces the amount of Your Monthly Benefit as described in REHABILITATION INCENTIVES. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.
5. recovery amounts that You receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings.

REDUCING YOUR DISABILITY BENEFIT BY THE ESTIMATED AMOUNT OF YOUR SOCIAL SECURITY BENEFITS

If there is a reasonable basis for You to apply for benefits under the Federal Social Security Act, We expect You to apply for them. To apply for Social Security benefits means to pursue such benefits until You receive approval from the Social Security Administration, or a notice of denial of benefits from an administrative law judge.

We will reduce the amount of Your Disability benefit by the amount of Social Security benefits We estimate that You, Your Spouse or child(ren) are eligible to receive because of Your Disability or retirement. We will start to do this after You have received 24 months of Disability benefit payments, unless We have received:

- approval of Your claim for Social Security benefits; or
- a notice of denial of such benefits indicating that all levels of appeal have been exhausted.

However, within 6 months following the date You became Disabled, You must:

- send Us Proof that You have applied for Social Security benefits;

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)

- sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance; and
- sign a release that authorizes the Social Security Administration to provide information directly to Us concerning Your Social Security benefits eligibility.

If You do not satisfy the above requirements, We will reduce Your Disability benefits by such estimated Social Security benefits starting with the first Disability benefit payment coincident with the date You were eligible to receive Social Security benefits.

In either case, when You do receive approval or final denial of Your claim for Social Security benefits as described above, You must notify Us immediately. We will adjust the amount of Your Disability benefit. You must promptly repay Us for any overpayment. We will promptly pay You for any underpayment.

SINGLE SUM PAYMENT

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If We adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

If You receive Other Income in the form of a single sum payment and We do not receive the Written Proof described above within 10 days after You receive the single sum payment, We will adjust the amount of Your Disability Benefit by the amount of such payment.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL NOT REDUCE YOUR DISABILITY BENEFIT

We will not reduce Your Disability benefit to less than the Minimum Benefit shown in the SCHEDULE OF BENEFITS, or by:

- cost of living adjustments that are paid under any of the above sources of Other Income;
- reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of Your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration;
- group credit insurance;
- mortgage disability insurance benefits;
- early retirement benefits that have not been voluntarily taken by You;
- veteran's benefits;
- individual disability income insurance policies;
- any Sick pay, vacation pay or other salary continuation that the Policyholder pays to You;
- benefits received from an accelerated death benefit payment; or
- amounts rolled over to a tax qualified plan unless subsequently received by You while You are receiving benefit payments.

DISABILITY INCOME INSURANCE: DATE BENEFIT PAYMENTS END

Your Disability benefit payments will end on the earliest of:

- the end of the Maximum Benefit Period;
- the date benefits end as specified in the section entitled LIMITED DISABILITY BENEFITS;
- the date You are no longer Disabled;
- the date You die except for benefits paid under section entitled ADDITIONAL LONG TERM BENEFIT: MONTHLY PAYMENT IN THE EVENT OF YOUR DEATH;
- the date You cease or refuse to participate in a Rehabilitation Program that We require;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date You fail to provide required Proof of continuing Disability.

While You are Disabled, the benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

DISABILITY INCOME INSURANCE

ADDITIONAL SHORT TERM BENEFIT: ORGAN DONOR

If You become Disabled as a result of an Organ Transplant Procedure while insured, Proof of the Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Organ Donor benefit shown below.

If We pay this benefit, You will not have to complete an Elimination Period.

BENEFIT AMOUNT

We will increase Your Weekly Benefit by an additional amount equal to 10% of Your Weekly Benefit. This increase will be applied to the first Weekly Benefit payment and continue while You remain Disabled, up to the Maximum Benefit Period.

DISABILITY INCOME INSURANCE

ADDITIONAL LONG TERM BENEFIT: MONTHLY PAYMENT IN THE EVENT OF YOUR DEATH

If You die while You are Disabled and You were entitled to receive Monthly Benefits under this certificate, Proof of Your death must be sent to Us. When We receive such Proof, We will pay the additional monthly benefit described in this section.

BENEFIT AMOUNT

The additional monthly benefit will be equal to 66 2/3% of the lesser of:

- the Monthly Benefit You receive for the calendar month immediately preceding Your death;
- the Monthly Benefit You were entitled to receive for the month You die, if You die during the first month that Monthly Benefits are payable.

We will reduce the benefit amount by any overpayment We are entitled to recover.

BENEFIT PAYMENT

We will pay this additional benefit monthly for a period of 3 months. Payments will begin one month after the date of the last Monthly Benefit payment before Your death.

Benefit payments will be made as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS PRE-EXISTING CONDITIONS

Pre-existing Condition means a Sickness or accidental injury for which You:

- received medical treatment, consultation, care, or services;
- took prescribed medication or had medications prescribed; or
- had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment;

in the 3 months before Your insurance under this certificate takes effect.

We will not pay benefits for a Disability that results from a Pre-existing Condition if You have been Actively at Work for less than 12 consecutive months after the date Your Disability insurance takes effect under this certificate.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS LIMITED DISABILITY BENEFITS

For Disability Due to Alcohol, Drug or Substance Abuse or Addiction

If You are Disabled due to alcohol, drug or substance abuse or addiction, We will limit Your Disability benefits to one period of Disability during your lifetime. During Your Disability, We require You to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a Physician.

We will end Disability benefit payments at the earliest of:

- the date You receive 24 months of Disability benefit payments;
- the date You cease or refuse to participate in the recovery program referred to above; or
- the date You complete such recovery program.

For Disability Due to Mental or Nervous Disorders or Diseases, Neuromuscular, Musculoskeletal or Soft Tissue Disorder, Chronic Fatigue Syndrome and related conditions

If You are Disabled due to one or more of the following, We will limit Your Disability benefits to a per occurrence maximum equal to the lesser of:

- 24 months; or
- the Maximum Benefit Period.

Your Disability benefits will be limited as stated above for:

1. a Mental or Nervous Disorder or Disease except for:
   - schizophrenia;
   - dementia; or
   - organic brain disease;
2. Neuromuscular, musculoskeletal or soft tissue disorder including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the Disability has objective evidence of:
   - Seropositive Arthritis;
   - Spinal Tumors, malignancy, or Vascular Malformations;
   - Radiculopathies;
   - Myelopathies;
   - Traumatic Spinal Cord Necrosis; or
   - Myopathies; or
3. Chronic fatigue syndrome and related conditions.

Mental or Nervous Disorder or Disease means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual Of Mental Disorders as of the date of Your Disability. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause.

Seropositive Arthritis means an inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease.

Spinal means components of the bony spine or spinal cord.

Tumor(s) means abnormal growths which may be malignant or benign.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS LIMITED DISABILITY BENEFITS (continued)

Vascular Malformations means abnormal development of blood vessels.

Radiculopathies means disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology.

Myelopathies means disease of the spinal cord supported by objective clinical findings of spinal cord pathology.

Traumatic Spinal Cord Necrosis means injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis.

Myopathies means disease of skeletal muscle supported by clinical, histological, biochemical and/or electrodiagnostic findings.

DISABILITY INCOME INSURANCE: EXCLUSIONS

We will not pay for any Disability caused or contributed to by:

1. war, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
2. Your active participation in a riot;
3. intentionally self-inflicted injury;
4. attempted suicide; or
5. commission of or attempt to commit or taking part in a felony.

We will not pay Short Term Benefits for any Disability caused or contributed to by elective treatment or procedures, such as:

1. cosmetic surgery or treatment primarily to change appearance;
2. sex-change surgery;
3. reversal of sterilization;
4. liposuction;
5. visual correction surgery; and
6. in vitro fertilization; embryo transfer procedure; or artificial insemination.

However, pregnancies and complications from any of these procedures will be treated as a Sickness

FILING A DISABILITY INCOME INSURANCE CLAIM: SHORT TERM BENEFITS

If You are unable to report for Active Work due to a Sickness or accidental injury, and You think that You may be Disabled, You should contact MetLife or Your benefits representative to initiate a claim.

When a claimant files an initial claim for Disability Income Insurance benefits described in this certificate, the notice of claim should be sent to Us within 14 days after the date Your Disability begins. The required Proof should be sent to Us within 90 days after the end of the Elimination Period.

Notice of claim and Proof for Disability Income Insurance may also be given to Us by following the process set forth below:

If Your benefit plan requires claims to be submitted through electronic and/or telephonic media, please see Your Employer for the details of this process.

The claimant must give Us Proof not later than 90 days after the end of the Elimination Period.

If Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given no later than 1 year after the time Proof is otherwise required except in the absence of legal capacity. You must notify us if You return to work in any capacity.

Items to be Submitted for a Disability Income Insurance Claim

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
  - the date Your Disability started;
  - the cause of Your Disability;
  - the prognosis of Your Disability;
  - the continuity of Your Disability; and
- Your application for:
  - Other Benefit Sources;
  - Federal Social Security disability benefits; and
  - Workers compensation benefits or benefits under a similar law.
- Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Benefit Sources;
- any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including:
    - histories,
    - physical, mental or diagnostic examinations; and
    - treatment notes; and
- the names and addresses of all:
  - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
  - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
- additional proof elements as required and described within the additional plan provisions for which you are filing a claim for benefits.

FILING A DISABILITY INCOME INSURANCE CLAIM: SHORT TERM BENEFITS (continued)

For Your Short Term Disability claim, We may request that You send Proof of continuing disability, satisfactory to Us, indicating that You are under the Regular Care of a Doctor. Proof of continuing Disability must be provided at Your expense, and must be received within 30 days of a request by Us. MetLife will deny Your claim or stop sending Your payments if the appropriate information is not submitted.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

Fraud and Material Misrepresentation

In the event that You, with intent to injure, defraud or deceive, provide any information or file a claim and/or supporting documentation that contains any false, incomplete or misleading information, including information or documentation that is materially false, Your claim for benefits under this certificate may be terminated or denied, and We may recover any overpayment that may result from such actions in accordance with the Overpayments provision above.

FILING A DISABILITY INCOME INSURANCE CLAIM: LONG TERM BENEFITS

If You are unable to report for Active Work due to a Sickness or accidental injury, and You think that You may be Disabled, You should contact MetLife or Your benefits representative to initiate a claim.

When a claimant files an initial claim for Disability Income Insurance benefits described in this certificate, the notice of claim should be sent to Us within 30 days after the date Your Disability begins. The required Proof should be sent to Us within 90 days after the end of the Elimination Period.

Notice of claim and Proof for Disability Income Insurance may also be given to Us by following the process set forth below:

If Your benefit plan requires claims to be submitted through electronic and/or telephonic media, please see Your Employer for the details of this process.

The claimant must give Us Proof not later than 90 days after the end of the Elimination Period.

If Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given no later than 1 year after the time Proof is otherwise required except in the absence of legal capacity. You must notify us if You return to work in any capacity.

Items to be Submitted for a Disability Income Insurance Claim

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
  - the date Your Disability started;
  - the cause of Your Disability;
  - the prognosis of Your Disability;
  - the continuity of Your Disability; and
- Your application for:
  - Other Benefit Sources;
  - Federal Social Security disability benefits; and
  - Workers compensation benefits or benefits under a similar law.
- Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Benefit Sources;
- any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including:
    - histories,
    - physical, mental or diagnostic examinations; and
    - treatment notes; and
- the names and addresses of all:
  - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
  - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
- additional proof elements as required and described within the additional plan provisions for which you are filing a claim for benefits.

FILING A DISABILITY INCOME INSURANCE CLAIM: LONG TERM BENEFITS (continued)

For Your Long Term Disability claim, We may request that You send Proof of continuing disability, satisfactory to Us, indicating that You are under the Regular Care of a Doctor. Proof of continuing Disability must be provided at Your expense, and must be received within 30 days of a request by Us. MetLife will deny Your claim or stop sending Your payments if the appropriate information is not submitted.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

Fraud and Material Misrepresentation

In the event that You, with intent to injure, defraud or deceive, provide any information or file a claim and/or supporting documentation that contains any false, incomplete or misleading information, including information or documentation that is materially false, Your claim for benefits under this certificate may be terminated or denied, and We may recover any overpayment that may result from such actions in accordance with the Overpayments provision above.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Disability Income Benefit Payments: Who We Will Pay

We will make any benefit payments during Your lifetime to You or Your legal representative as Beneficiary. Any payment made in good faith will discharge Us from liability to the extent of such payment.

Upon Your death, We will pay any amount that is or becomes due to Your designated Beneficiary. If there is no Beneficiary designated or no surviving designated Beneficiary at Your death, We may determine the Beneficiary for any amount that is or becomes due, according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your parent(s), if there is no surviving child(ren);
4. Your sibling(s), if there is no surviving parent(s);
5. Your estate, if there is no such surviving sibling(s).

If more than one person is eligible to receive payment, We will divide the benefit amount in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Any periodic payments owed to Your estate may be paid in a single sum.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid Insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest Disability Insurance after it has been in force for 2 years during Your life. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life.

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

GENERAL PROVISIONS (continued)

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Physical Exams

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

Overpayments for Disability Income Insurance

Recovery of Overpayments

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

- the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us. Our rights and Your obligations in this regard are described in the reimbursement agreement that You are required to sign when You submit a claim for benefits under this certificate. This agreement:

- confirms that You will reimburse Us for all overpayments; and
- authorizes Us to obtain any information relating to sources of Other Income.

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future Disability benefits, including the Minimum Benefit, payable to You or any other payee under the Disability sections of this certificate;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

GENERAL PROVISIONS (continued)

Lien and Repayment

If You become Disabled and You receive Disability benefits under this certificate and You receive payment from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate (for example, a judgment, settlement, payment from Federal Social Security or payment pursuant to Workers' Compensation laws), You shall reimburse Us from the proceeds of such payment up to an amount equal to the benefits paid to You under this certificate for such Disability. Our right to receive reimbursement from any such proceeds shall be a claim or lien against such proceeds and Our right shall provide Us with a first priority claim or lien over any such proceeds up to the full amount of the benefits paid to You under this certificate for such Disability. You agree to take all action necessary to enable Us to exercise Our rights under this provision, including, without limitation:

- notifying Us as soon as possible of any payment You receive or are entitled to receive from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate;

- furnishing of documents and other information as requested by Us or any person working on Our behalf; and

- holding in escrow, or causing Your legal representative to hold in escrow, any proceeds paid to You or any party by a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate, up to an amount equal to the benefits paid to You under this certificate for such Disability, to be paid immediately to Us upon Your receipt of said proceeds.

You shall cooperate and You shall cause Your legal representative to cooperate with Us in any recovery efforts and You shall not interfere with Our rights under this provision. Our rights under this provision apply whether or not You have been or will be fully compensated by a third party for any Disability for which You received or are entitled to receive benefits under this certificate.

THIS IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

Social Security Assistance Program

If your claim for Disability benefits under this plan is approved, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply For Social Security Disability Benefits

Both you and your employer contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security's program of disability protection. Since your tax dollars help fund this program, it is in your best interest to apply for any benefits to which you may be entitled. Your spouse and children may also be eligible to receive Social Security disability benefits due to your Disability.
There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

1. **Avoids Reduced Retirement Benefits**

   Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivors benefit.

2. **Medicare Protection**

   Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

3. **Trial Work Period**

   Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

4. **Cost-of-Living Increases Awarded by Social Security Will Not Reduce Your Disability Benefits**

   MetLife will not decrease your Disability benefit by the periodic cost-of-living increases awarded by Social Security. This is also true for any cost-of-living increases awarded by Social Security to your spouse and children.

   This is called a Social Security "freeze." It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your Disability benefit; with the following exceptions:

   a) an error by Social Security in computing the initial amount;
   b) a change in dependent status; or
   c) your Employer submitting updated earnings records to Social Security for earnings received prior to your Disability.

   Over a period of years, the net effect of these cost-of-living increases can be substantial.

How MetLife Assists You in the Social Security Approval Process

As soon as you are approved for Disability benefits, MetLife begins assisting you with the Social Security approval process.

1. **Assistance Throughout the Application Process**

   MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department.

They provide expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

2. Guidance Through Appeal Process by Social Security Specialists

Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provides expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:

a) Reconsideration by the Social Security Administration

b) Hearing before an Administrative Law Judge

c) Review by an Appeals Council established within the Social Security Administration in Washington, D.C.

d) A civil suit in Federal Court.

3. Social Security Attorneys

Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security approved attorney's fee is credited to the Long Term Disability overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum Social Security Disability benefits award and will not be used to further reduce your Long Term Disability benefit.

Early Intervention Program

The MetLife Early Intervention Program is offered to all covered employees, and your participation is voluntary*. The program helps identify early those employees who might benefit from vocational analyses and rehabilitation services before they are eligible for Long Term Disability benefits. Early rehabilitation efforts are more likely to reduce the length of your Long Term Disability and help you return to work sooner than expected.

If you cannot work, or can only work part-time due to a disability, your employer will notify MetLife. Our Clinical Specialists may be able to assist you by:

1. Reviewing and evaluating your disabling condition, even before a claim for Long Term Disability benefits is submitted (with your consent);
2. Designing individualized return to work plans that focus on your abilities, with the goal of return to work;
3. Identifying local community resources;
4. Coordinating services with other benefit providers, including: medical carrier, short term disability carrier,* workers' compensation carrier, and state disability plans;
5. Monitoring return to work plans in progress and modifying them as recommended by the attending physician (with your consent).

Our assistance is offered at no cost to either you or your employer.

* If you also have MetLife Short Term Disability coverage or Salary Continuance Plan Management, these services are provided automatically. Notification by your employer is not necessary.

Return To Work Program

Goal of Rehabilitation
The goal of MetLife is to focus on employees' abilities, instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what employees can do versus what they can't, we can assist you in returning to work sooner than expected.

Incentives For Returning To Work
Your Disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable, but you do not participate in the Return to Work Program, your Disability benefits may cease.

Return-to-Work Services
As a covered employee you are automatically eligible to participate in our Return-to-Work Program. The program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities. There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. **Vocational Analyses**

   Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your employer.

2. **Labor Market Surveys**

   Studies to find jobs available in your locale that would utilize your abilities and skills. Also identify one's earning potential for a specific occupation.

3. **Retraining Programs**

   Programs to facilitate return to your previous job, or to train you for a new job.

4. **Job Modifications/Accommodations**

   Analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities.

   This also includes changes in your job or accommodations to help you perform the previous job or a similar vocation, as required of your employer under the Americans With Disabilities Act (ADA).

5. **Job Seeking Skills and Job Placement Assistance**

   Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

Return-to-Work Program Staff
The Case Manager handling your claim will coordinate return-to-work services. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist, or Vocational Rehabilitation Consultant, who has advanced training and education to help people with disabilities return to work. One of our clinical specialists will work with you directly, as well as with local support services and resources. They have returned hundreds of individuals to meaningful, gainful employment.

Rehabilitation Vendor Specialists
In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. attending physician's evaluation and recommendations;
2. your individual vocational needs; and
3. vendor's credentials, specialty, reputation and experience.

When working with vendors, we continue to collaborate with you and your doctor to develop an appropriate return-to-work plan.

MetLife®

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.: **307601-1-G**

Policyholder: **Board of Regents of the University System of Georgia**

Effective Date: **January 1, 2015**

The certificate is changed as follows:

Applicable to Disability Income Insurance: Short Term and Long Term Benefits for All Full-Time Employees

1. In **DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT**, replace item 3 with the following:

   "1. any income received for disability under:
   - a group insurance policy to which the Policyholder has made a contribution, such as:
     - benefits for loss of time from work due to disability;
     - installment payments for permanent total disability;
   - a no-fault auto law for loss of income, excluding supplemental disability benefits;
   - a government compulsory benefit plan or program which provides payment for loss of time from Your job due to Your disability, whether such payment is made directly by the plan or program, or through a third party;
   - a self-funded plan, or other arrangement if the Policyholder contributes toward it or makes payroll deductions for it;
   - any sick pay, vacation pay or other salary continuation that the Policyholder pays to You;
   - workers' compensation or a similar law which provides periodic benefits;
   - occupational disease laws;
   - laws providing for maritime maintenance and cure;
   - unemployment insurance law or program; and
   - any income that You receive from working while Disabled to the extent that such income reduces the amount of Your Weekly Benefit as described in REHABILITATION INCENTIVES. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.
   - recovery amounts that You receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings."

2. In **DISABILITY INCOME INSURANCE: INCOME WHICH WILL NOT REDUCE YOUR DISABILITY BENEFIT**, delete the following:

   "any Sick pay, vacation pay or other salary continuation that the Policyholder pays to You;"

This rider is to be attached to and made part of the certificate.

CR2000

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
ATHENS DIVISION

SKYLER MUSGROVE,

Plaintiff,

v.

THE BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA, JAMES HULL, in his official capacity as Chair of the Board of Regents of the University System of Georgia, UNIVERSITY OF GEORGIA, JERE MOREHEAD, in his official capacity as President of the University of Georgia, KARIN ELLIOTT, in her official capacity as Interim Vice Chancellor of Human Resources of the University System of Georgia, BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA, INC., METROPOLITAN LIFE INSURANCE COMPANY, and METLIFE, INC.

Defendants.

Civil Action No.

JURY TRIAL DEMANDED

COMPLAINT FOR DAMAGES

Plaintiff Skyler Musgrove, by and through his attorneys, files this Complaint against Defendants, the Board of Regents of the University System of Georgia, James Hull, in his official capacity as Chair of the Board of Regents of the University System of Georgia, University of Georgia, Jere Morehead, in his official capacity as President of the University of Georgia, Karin Elliott, in her official capacity as University System of Georgia Interim Vice Chancellor of Human Resources, Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Metropolitan Life Insurance Company, and MetLife, Inc., and respectfully states as follows:

INTRODUCTION

1. This case is about equal benefits for equal work. Plaintiff Skyler Musgrove ("Mr. Musgrove") works as a Catering and Banquets Manager at the University of Georgia. As part of its employment compensation, Defendant University of Georgia ("UGA") provides long- and short-term disability coverage and health care coverage, including the University System of Georgia Consumer Choice HSA Healthcare Plan ("Health Plan") that covers Mr. Musgrove.

2. Employees contribute part of their paychecks to the short-term disability plan and the Health Plan. Mr. Musgrove contributes the same amount as do his co-workers, but he receives unequal benefits in return. Employees generally receive coverage for their medically necessary care and disability-leave needs. In contrast, Mr. Musgrove has been forced to incur thousands of dollars in out-of-pocket costs to obtain medically necessary care without the financial protections afforded by the Health Plan or the short-term disability plan. This is because UGA expressly excludes the medical care he needs—not because the treatment isn't medically necessary or widely recognized as effective, but solely due to the historical stigmatization of his medical condition.

3. Mr. Musgrove has gender dysphoria, a serious medical condition and disability that arises when the sex of the brain develops on a divergent path from the external sex characteristics of the body. A well-established medical consensus finds that hormonal and surgical treatment to align external sex characteristics with the brain is successful in alleviating gender dysphoria. Accordingly, such medically necessary treatments are widely covered under public and private health insurance plans.

4. Mr. Musgrove suffers emotional distress, humiliation, and a loss of dignity because of this targeted discrimination and categorical dismissal of his medical needs.

5. Mr. Musgrove brings this action seeking declaratory and injunctive relief and damages caused by the discriminatory denial of medically necessary care and related disability leave.

JURISDICTION AND VENUE

6. This is a civil rights complaint for discrimination on the basis of disability and sex under the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101, et seq. ("ADA"), Section 504 of the Rehabilitation Act, 29 U.S.C. § 701 ("Section 504"), Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, et seq. ("Title VII"), Title I of the Civil Rights Act of 1991, 42 U.S.C. § 1981a, Title IX of the Educational Amendments of 1972, 20 U.S.C. § 1681, et. seq. ("Title IX"), and pursuant to 42 U.S.C. § 1983 for discrimination based on disability, sex, and transgender status in violation of the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution, U.S. Const. amend. XIV, § 1.

7. The Court has jurisdiction pursuant to Article III of the United States Constitution; 28 U.S.C. §§ 1331, 1343; and 42 U.S.C. § 2000e-5(f)(3).

8. Plaintiff's claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202 and 42 U.S.C. § 1983.

9. Under 28 U.S.C. § 1391, venue is proper in the Middle District of Georgia because Defendant University of Georgia resides and is subject to personal jurisdiction in the District and a substantial part of the events or omissions giving rise to the claim occurred in Athens, Georgia.

10. This action arises in the Athens Division because a substantial part of the events or omissions that give rise to the claim occurred at UGA's headquarters in Athens, Georgia.

PARTIES

11. Plaintiff Skyler Musgrove resides in Athens, Georgia.

12. The University of Georgia ("UGA") is a public institution of higher education. Its main campus is located in Athens, Georgia. UGA is part of the University System of Georgia, which is governed by the Board of Regents of the University of Georgia.

13. Jere Morehead, President of the University of Georgia, has his office in Athens, Georgia. Office of the President Administration Building 220 South Jackson Street Athens, Georgia 30602-1661

14. The Board of Regents of the University System of Georgia ("Board" or "Board of Regents"), an agency of the State of Georgia, has exclusive power over "[t]he government, control, and management of the University System of Georgia," Ga. Const. art. VIII, § 4, para. 1(b). The Board is headquartered in Atlanta, Georgia.

15. James Hull, is Chair of the Board of Regents of the University System of Georgia, which is headquartered in Atlanta, Georgia.

16. Karin Elliott is the Interim Vice Chancellor of Human Resources of the University System of Georgia. Her office is in Atlanta, Georgia.

17. Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. ("BCBS") is a for-profit corporation organized under the laws of Georgia. It administers the Health Plan. It has a principle office address in Indianapolis, Indiana and its corporate headquarters are located in Atlanta, Georgia.

18. The University System of Georgia's disability insurance is administered by Metropolitan Life Insurance Company, a part of MetLife, Inc., a for-profit corporation organized under the laws of Delaware (both referred to collectively hereinafter as "MetLife"). MetLife, Inc.'s corporate headquarters are located in New York, New York.

19. At all relevant times, UGA is and has been a "person" and "employer" as defined under the ADA, Section 504, and Title VII and is accordingly subject to the provisions of each said act.

20. At all relevant times, the Board is and has been a "person" and "employer" as defined under the ADA, Section 504, and Title VII and is accordingly subject to the provisions of each said act.

21. The Board is a recipient of federal funds from the U.S. Department of Education, and, as such, is subject to Section 504 and Title IX.

22. UGA is a recipient of federal funds from agencies including the U.S. Department of Education, the U.S. Department of Agriculture, and the U.S. Department of Health and Human Services, and, as such, is subject to Section 504 and Title IX.

EXHAUSTION OF ADMINISTRATIVE REQUIREMENTS

23. On February 20, 2018, Plaintiff timely filed a charge with the Equal Employment Opportunity Commission against the Board, UGA, BCBS, and MetLife for sex discrimination in violation of Title VII and disability discrimination in violation of the ADA.

24. The right-to-sue, dated March 27, 2018, was postmarked March 28, 2018.

25. Mr. Musgrove brings this action within ninety (90) days of the March 31, 2018, receipt of a right-to-sue letter issued by the EEOC, a true and accurate copy of which is attached hereto as Exhibit A.

FACTUAL BACKGROUND

26. A nearly life-long resident with deep roots in Georgia, Mr. Musgrove began attending UGA in the Spring of 2008. He was a dual-degree student studying anthropology and mass media studies.

27. In approximately 2009, Mr. Musgrove was diagnosed with gender dysphoria. During his time as a UGA student, Mr. Musgrove publicly came out as a man and socially transitioned from female to male. He experienced challenges as a result of coming out as male—including being verbally and physically assaulted, both on and off campus. He was unable to focus on his studies and took two medical withdrawals. In 2012, he stopped attending school, just three courses shy of earning his degrees. He knew that medical transition was what would enable him to complete his studies.

28. As he was without health insurance, Mr. Musgrove decided to work full-time in order to save money for the surgery he needed to treat his gender dysphoria. Mr. Musgrove began working at UGA and has been employed continuously there since 2013. He has been promoted several times over the years and currently is a manager working in event planning.

Gender Dysphoria and its Treatment

29. The standard of care for treatment of gender dysphoria, established by the World Professional Association for Transgender Health ("WPATH"), the American Medical Association ("AMA"), the American Psychological Association ("APA"), and other major medical and mental health professional organizations, includes counseling, hormone therapy, gender reassignment surgery, as well as living openly as one's affirmed sex—in Mr. Musgrove's case, male.

30. Because gender dysphoria is readily treated through the use of hormones and surgery, it is widely covered under public and private health insurance plans. All major insurance companies have published clinical policy guidelines recognizing transgender surgeries as medically necessary and setting out basic standards that must be met before coverage is approved, such as a diagnosis of gender dysphoria, capacity to provide informed consent, and a letter of recommendation from a mental health provider.

31. A transgender person is someone whose external sex characteristics at birth do not match their brain sex or psychological sex—the innate, internal sense of being male or female, that all people have.[1] Typically, people born with the physical characteristics of males are psychologically male, and those with the physical characteristics of females are psychologically female. However, for a transgender person, body and brain do not match.

32. This incongruence results in gender dysphoria—i.e., a feeling of great stress and discomfort with the experience that something is fundamentally wrong. Such distress, if clinically significant and persistent, is a serious medical condition.

33. In 1980, the American Psychiatric Association introduced the diagnosis of gender identity disorder ("GID") in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). This diagnosis remained in subsequent versions of the DSM issued in 1987 (DSM-III-R) and 1994 (DSM-IV).

34. In 2013, the DSM-5 removed the diagnosis of GID and replaced it with a fundamentally different diagnosis called gender dysphoria that is based on significant changes in our understanding of individuals whose external sex characteristics at birth do not match their brain sex. Importantly, consistent with the change in nomenclature, the new diagnosis reflects that the incongruence between a person's brain sex and physical sex is no longer by itself considered to be a disorder, but rather the critical element of the condition is the presence of clinically significant distress that results from such an incongruence.

[1] Brain sex, sometimes referred to as "gender identity," is often invisible to people whose psychological sex matches their external sex characteristics. It can be made more visible through a thought experiment of asking how much money someone would have to pay you to transition socially, medically, and legally and live as the other sex for the rest of your life.

35. There is now a scientific consensus that brain sex is biologically based, and a significant body of scientific and medical research that gender dysphoria has a physiological and biological etiology that emanates from an atypical interaction of sex hormones with the developing brain.[2] The scientific evidence also demonstrates different brain composition in transgender women and men, and a significant co-occurrence of gender dysphoria in families and twins.

36. The World Professional Association for Transgender Health ("WPATH") is an interdisciplinary professional and educational organization devoted to transgender health. WPATH has established internationally-accepted *Standards of Care* ("SOC") for the treatment of people with gender dysphoria. Major medical and mental health organizations, including the American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association, have endorsed the SOC as the authoritative standards of care.

37. The treatment for gender dysphoria is to assist the person in undergoing a gender transition that will alleviate the distress caused by gender dysphoria and allow the person to live in alignment with the person's affirmed sex. When left untreated, gender dysphoria can result in serious psychological debilitation, including depression, anxiety, suicidality, and other mental health issues.

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[2] *See, e.g., See, e.g.,* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 457 (5th ed. 2013) (discussing genetic and hormonal contributions to gender dysphoria); Christine Michelle Duffy, *The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973, in* GENDER IDENTITY AND SEXUAL ORIENTATION DISCRIMINATION IN THE WORKPLACE: A PRACTICAL GUIDE 16-72 to 16-74 & n.282 (Christine Michelle Duffy ed., Bloomberg BNA 2014) (citing numerous medical studies conducted in past eight years that "point in the direction of hormonal and genetic causes for the in utero development of Gender Dysphoria").

38. The transition process has three main components—social, pharmacological, and surgical:

a. Social transition involves bringing a person's gender expression and social sex role into alignment with their affirmed sex. It may include wearing clothes, using a different name and pronouns, and interacting with peers and one's social environment in a manner that matches the person's affirmed sex.

b. A transgender person may also decide to take medications that change the hormone balance in their bodies to be consistent with the person's affirmed sex. For example, a transgender man would take medications that reduce estrogen and replace those hormones with testosterone, which will further masculinize that person's sex characteristics.

c. Lastly, a transgender person may pursue surgical treatment to alleviate dysphoria caused by having incongruent primary and secondary sex characteristics.

39. The precise medical treatments required to alleviate a particular individual's gender dysphoria may vary based on the person's individualized medical needs.

Defendants' Denial of Mr. Musgrove's Medically Necessary Care

40. When he was made a full-time employee in September 2015, Mr. Musgrove had one month to choose a benefits package. He asked Human Resources which plan would cover his treatments for gender dysphoria. He was informed that all health plans had a list of excluded treatments, which included treatments for gender dysphoria, so no matter which plan he chose, he would be denied coverage for the care that he needed.

41. Mr. Musgrove reached out to Monica P. Fenton, Director of System Benefits—Healthcare & Pharmacy, of the Board of Regents of the University System of Georgia. He requested to address the Board and ask that the exclusion be removed. He received no response.

42. Human Resources also informed Mr. Musgrove that his short-term disability insurance would not provide coverage for surgery to treat gender dysphoria. He would have to rely on his personal vacation and medical leave time to have an income during recovery. He began forgoing as many vacation and sick days as possible while attempting to accumulate as many days off as possible to allow for recovery from surgery.

43. In 2017, Mr. Musgrove was covered under the University System of Georgia Consumer Choice HSA Healthcare Plan. He is currently covered under the 2018 version of the same plan. This health plan is offered to all full-time UGA employees. As with other Health Plan participants, he currently contributes $75.12 per month for health benefits.

44. The Health Plan covers medically necessary prescription drugs and surgery including physician services, anesthesia, and hospital expenses. Yet the Health Plan explicitly excludes the following services: "Sex Change – Services or supplies for a sex change and/or the reversal of a sex change," and "Sex Change Drugs – Drugs for sex change surgery."[3] (Exhibit B at 53, 98.) These exclusions remain in the 2018 plan. But for these exclusions, gender dysphoria treatments would be covered under the plan on the same terms as any other widely-recognized, medically necessary care.

[3] "Sex change" is an archaic and disfavored term that is not used in the medical community. Under contemporary medical and psychological understanding, gender dysphoria-related medical treatments make visible, but do not "change," an individual's sex by bringing primary and secondary sex characteristics into alignment with the person's brain sex.

45. As a UGA employee, Mr. Musgrove also participates in the Board's Disability Income Insurance: Short Term Benefits and Long Term Benefits plan ("Disability Insurance"). This short and long-term disability income insurance is offered to all full-time UGA employees. As with other Disability Insurance participants, Mr. Musgrove currently contributes $6.03 per biweekly paycheck for short-term disability benefits. The Disability Insurance plan administered by MetLife contains an exclusion for short term benefits for any disability caused by "sex-change surgery." (Exhibit C at 51.)

46. Mr. Musgrove required surgery to treat his gender dysphoria. Mr. Musgrove had a long-standing, debilitating discomfort with his typically female chest. To alleviate the gender dysphoria caused by his chest, he bound his breasts to establish a flat, typically male chest. Mr. Musgrove bound his chest for a period of nine years, which restricted his breathing, made it not possible to engage in physical exercise, and contributed to a persistent dry couch.

47. In 2012, Mr. Musgrove started testosterone therapy to help alleviate his gender dysphoria. As a result, he developed a typical male appearance and secondary sex characteristics, including a full beard and a typically male voice. This heightened his need for chest surgery as having typically female breasts on a male not only exacerbated his gender dysphoria, it also presented a safety risk when in public. Mr. Musgrove experienced anxiety and a withdrawal from social activities due to his chest dysphoria. He also experienced a loss of concentration and ability to focus and learn.

48. After accruing days off, Mr. Musgrove located a qualified surgeon experienced with performing chest surgery to treat gender dysphoria. On February 7, 2017, Mr. Musgrove had a telephone consultation with his surgeon, Dr. Hope Sherie, who is located in Charlotte, North Carolina.

49. On April 19, 2017, Mr. Musgrove's surgeon applied for preauthorization with BCBS. In a letter dated April 26, 2017, BCBS declined to preauthorize coverage for surgery stating, "We cannot approve your request for coverage of breast removal for transgender surgery. This request is not covered by your plan. It is listed as an excluded benefit in your certificate of coverage manual, page 53 and 55." (Exhibit D.)

50. Mr. Musgrove underwent surgery to treat gender dysphoria on May 30, 2017. Mr. Musgrove's surgeon was an out-of-network provider with BCBS but assisted Mr. Musgrove with submitting the claim to BSBS. Mr. Musgrove learned he suffered financial injury after receiving an Explanation of Benefits dated October 10, 2017. BCBS denied the $8333.32 claim for surgery stating, "This is not a covered expense of the patient's plan." (Exhibit E.)

51. On April 7, 2018, Mr. Musgrove appealed the denial of his claim. In a letter dated April 24, 2018, BCBS denied his appeal stating that because the plan is self-insured, it had "no flexibility" to override the plan exclusion. (Exhibit F.)

52. BCBS denied coverage despite the fact that, in general, BCBS recognizes the medical necessity of surgery to treat gender dysphoria. Since 2006, Blue Cross Blue Shield of Georgia has had a medical policy on Sex Reassignment Surgery.[4] It details the criteria—which Mr. Musgrove has met—that determine when gender reassignment surgery is medically necessary for a given individual. But for the exclusion, BCBS would have approved his surgery as medically necessary.

[4] Blue Cross Blue Shield of Georgia, Clinical UM Guideline CG-SURG-27: Sex Reassignment Surgery (Aug. 17, 2017), https://www.bcbsga.com/medicalpolicies/guidelines/gl_pw_a051166.htm.

53. Mr. Musgrove has paid out of pocket for a medically necessary procedure and he has not been reimbursed. He previously and currently pays into an insurance plan that does not cover him to the same extent it covers his coworkers based on his disability and sex.

54. Mr. Musgrove did not apply for short-term disability for his surgery because Human Resources told him he was not eligible. They did not provide the paperwork to apply. He had to use his personal vacation and medical days off during his surgery recovery. Mr. Musgrove was denied the opportunity to receive short-term disability income following a medically necessary surgery. He previously and currently pays into an insurance plan that does not cover him to the same extent it covers his coworkers based on his disability and sex.

55. Mr. Musgrove took steps to resolve the issue including speaking with Human Resources, filing a claim and appeal with BCBS, and contacting via counsel UGA's General Counsel and the Legal Department of the Board of Regents. He also submitted via counsel a request to Chancellor Steve Wrigley to appear to raise the issue at the January 11, 2018, meeting of the Board of Regents, the body responsible for determining coverage. He was denied an in-person appearance and submitted written materials only.

56. When he went to re-enroll for benefits during the open enrollment period at the end of 2017, Mr. Musgrove asked Human Resources if there had been any changes in coverage for treatments of gender dysphoria. He was informed there were not, so he remained on the Health Plan.

57. UGA offers four different health plans to all employees to allow them to make the best choice for themselves in terms of provider network, premium cost, and cost-sharing. In a letter dated February 12, 2018, Karin Elliott acknowledged that all three self-funded health care plans offered by the University System of Georgia exclude treatments for gender dysphoria. (Exhibit G.)

All of the Board's self-funded health plans are administered by BCBS, but Ms. Elliott stated that the Kaiser Permanente HMO did not have an exclusion.

58. Although he asked, Human Resources did not inform Mr. Musgrove about the Kaiser Permanente HMO plan prior to undergoing surgery or prior to enrolling in the 2018 plan.

59. The vast majority of UGA employees choose one of the self-funded BCBS plans. Mr. Musgrove is denied the same range of choices as non-transgender co-workers because only one plan does not exclude the medically necessary care that he needs. Contracting with one third-party HMO that does not discriminate in its plan while the Board persists in excluding medically necessary care does not address the inequity in plan choices, plan coverage, or the stigma caused by having exclusions at all. The simple existence of "sex change" exclusions—which lack a legitimate, nondiscriminatory basis—devalues the medical needs of Mr. Musgrove and all employees with gender dysphoria and contributes to a hostile work environment on the basis of disability and sex.

60. Mr. Musgrove would also be harmed by being forced to switch to the Kaiser HMO. There is dearth of providers who are experienced treating transgender patients, and Mr. Musgrove has had negative experiences with providers unfamiliar with transgender patients. Switching to the Kaiser HMO would force him to switch primary care providers, use a limited network of physicians, pay a monthly premium that is over twice as much, and he would have an extremely narrow choice of surgeons in the Kaiser network to perform the specialized surgeries to treat gender dysphoria that he still requires.

61. The discrimination against Mr. Musgrove remains on-going as long as the exclusions for gender dysphoria treatments remain in the self-funded health plans and Disability Insurance. Mr. Musgrove requires additional surgeries to treat his gender dysphoria. He also needs

prescription drug coverage for his on-going testosterone therapy, but this is also excluded under the plan. As a result of the Health Plan and Disability Insurance exclusions, Mr. Musgrove is forced to either forego medically necessary treatment due to a lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

FIRST CAUSE OF ACTION

Unlawful Discrimination on the Basis of Disability in Violation of Title I of the Americans with Disabilities Act

Against All Defendants (for compensatory damages, declaratory relief, and injunctive relief)

62. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

63. Title I of the ADA provides that "[n]o covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." 42 U.S.C. § 12112(a).

64. Under Title I of the ADA, a "covered entity" means a person—including "one or more individuals, governments, [or] governmental agencies," 42 U.S.C. § 2000e—"engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, *and* any agent of such person . . . ." 42 U.S.C. §§ 12111(2), (5)(A), (7) (citing 42 U.S.C. § 2000e).

65. Under Title I of the ADA, a "qualified individual" means an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." 42 U.S.C. §§ 12111(8).

66. Title I of the ADA prohibits disparate treatment of a qualified individual with a disability, including: (i) "limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee"; (ii) "participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity's qualified applicant or employee with a disability to the discrimination prohibited by this subchapter (such relationship includes a relationship with an employment or referral agency, labor union, an organization providing fringe benefits to an employee of the covered entity, or an organization providing training and apprenticeship programs)"; and (iii) "excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association." 42 U.S.C. § 12111(b)(1)-(2), (4); *see also* 29 C.F.R. §§ 1630.4 - 1630.8.

67. Title I of the ADA prohibits conduct that has a disparate impact on a qualified individual with a disability, including: (i) "utilizing standards, criteria, or methods of administration . . . that have the effect of discrimination on the basis of disability"; and (ii) "using qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity." 42 U.S.C. § 12111(b)(3), (6); *see also* 29 C.F.R. §§ 1630.7, 1630.10.

68. Title I of the ADA prohibits "not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would

impose an undue hardship on the operation of the business of such covered entity; or . . . denying employment opportunities to a job applicant or employee who is an otherwise qualified individual with a disability, if such denial is based on the need of such covered entity to make reasonable accommodation to the physical or mental impairments of the employee or applicant. 42 U.S.C. § 12111(b)(5); *see also* 29 C.F.R. § 1630.9.

69. Because of the date of the actions complained of, the expanded definition of "disability" under the Americans with Disabilities Act Amendments Act of 2008 ("ADAAA") applies.

70. Under the ADAAA and EEOC regulations interpreting the ADA, as amended, the definition of disability is to be construed broadly in favor of expansive coverage. 42 U.S.C. § 12102(4)(A); 28 C.F.R. §§ 35.108(a)(2)(i), 35.108(d)(1)(i). Accordingly, the terms "substantially" and "major" in the definition of disability are to be interpreted consistently with the ADAAA's findings and purposes, which reinstate "the broad scope of protection intended to be afforded by the ADA" and convey Congress's intent "that the question of whether an individual's impairment is a disability under the ADA should not demand extensive analysis." 42 U.S.C. §§ 12102(4)(B), ADA Amendments Act of 2008, Pub. L. No. 110-325, §§ (2)(a)(5), (b)(5).

71. In determining disability, the ADAAA requires that impairments must be assessed "without regard to the ameliorative effects of mitigating measures," such as medication, therapy, and reasonable accommodations. 42 U.S.C. § 12102(4)(E)(i).

72. In determining disability, the ADAAA requires that impairments that are "episodic or in remission" must be assessed in their active state. 42 U.S.C. § 12102(4)(D).

73. In determining disability, a "major life activity" includes "the operation of a major bodily function," including neurological, brain, and reproductive functions. 42 U.S.C. § 12102(2)(B); *see also* 29 C.F.R. § 1630.2(i).

74. Under the ADAAA and regulations interpreting the ADA, as amended, "an individual meets the requirement of 'being regarded as having' an impairment that substantially limits one or more major life activities if the individual establishes that he or she has been subjected to an action prohibited under th[e ADA] because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity." 42 U.S.C. §§ 12102(3)(A); *see also* 29 C.F.R. § 1630.2(l); ADA Amendments Act of 2008, Pub. L. No. 110-325, § (2)(b)(3) (reinstating "broad view of the third prong" of the definition of disability). Accordingly, no showing of substantial limitation of a major life activity is required under the regarded-as prong. 29 C.F.R. § § 1630.2(g)(3) ("[T]he 'regarded as' prong of the definition of disability . . . does not require a showing of an impairment that substantially limits a major life activity or a record of such an impairment.").

75. UGA and the Board are covered entities within the meaning of Title I of the ADA.

76. BCBS, and MetLife, as agents of UGA and the Board, are covered entities within the meaning of Title I of the ADA. *See* EEOC COMPLIANCE MANUAL, No. 915.003, 2-III(B)(2)(b) (2000), https://www.eeoc.gov/policy/docs/threshold.html ("An entity that is an agent of a covered entity is liable for the discriminatory actions it takes on behalf of the covered entity. For example, an insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent.").

77. UGA and the Board violated Title I of the ADA by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Adopting a healthcare policy that excludes treatment for gender dysphoria, and participating in a contractual or other arrangement or relationship with BCBS and MetLife that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Title I of the ADA.

b. Adopting a healthcare policy that has the effect of discrimination on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably accommodate Mr. Musgrove by modifying the healthcare policy to include treatment for gender dysphoria.

78. BCBS, and MetLife violated Title I of the ADA by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Offering a healthcare policy that excludes treatment for gender dysphoria, and participating in a contractual or other arrangement or relationship with UGA and the Board that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Title I of the ADA.

b. Offering a healthcare policy that has the effect of discriminating on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably accommodate Mr. Musgrove by modifying the healthcare policy to include treatment for gender dysphoria.

79. Mr. Musgrove is a qualified individual under Title I of the ADA because he can perform the essential functions of his job, with or without reasonable accommodation.

80. Mr. Musgrove has a disability within the meaning of the ADA, as amended.

81. Mr. Musgrove suffers from gender dysphoria, which is a "physical or mental impairment" under the ADA. *See* 29 C.F.R. § 1630.2(h); *see also* 28 C.F.R. §§ 35.108(b)(1), 36.105(b)(1).

82. Gender dysphoria is not excluded under the ADA, 42 U.S.C. § 12211(b)(1) (excluding from definition of disability "gender identity disorders not resulting from physical impairments"), because gender dysphoria is a gender identity disorder "that results from [a] physical impairment[]." *Id.* The burgeoning medical research underlying gender dysphoria points to a physical etiology—namely, an atypical interaction of sex hormones and the developing brain that results in a person being born with circulating hormones inconsistent with the person's brain sex.[5] This atypical interaction of sex hormones and the brain is a "physiological . . . condition . . . affecting one or more body systems," including "neurological . . . [and] endocrine" systems. 29 C.F.R. § 1630.2(h)(1); *see also* 28 C.F.R. §§ 35.108(b)(1)(i), 36.105(b)(1)(i). In 2015, the U.S. Department of Justice concluded that:

> While no clear scientific consensus appears to exist regarding the *specific* origins of gender dysphoria (*i.e.*, whether it can be traced to neurological, genetic, or hormonal sources), the current research increasingly indicates that gender dysphoria has physiological or biological roots. . . . [i]n light of the evolving scientific evidence suggesting that gender dysphoria may have a physical basis, along with the remedial nature of the ADA and the relevant statutory and regulatory provisions directing that the terms 'disability' and 'physical impairment' be read broadly, the [ADA's exclusion of gender identity disorders not resulting from physical impairments] should be construed narrowly such that gender dysphoria falls outside its scope.

[5] *See, e.g.*, AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 457 (5th ed. 2013) (discussing genetic and hormonal contributions to gender dysphoria); Christine Michelle Duffy, *The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973*, *in* Gender Identity and Sexual Orientation Discrimination in the Workplace: A Practical Guide 16-72 to 16-74 & n.282 (Christine Michelle Duffy ed., Bloomberg BNA 2014) (citing numerous medical studies conducted in past eight years that "point in the direction of hormonal and genetic causes for the in utero development of gender dysphoria").

Second Statement of Interest of the United States at 5, *Blatt v. Cabela's Retail, Inc.*, No. 5:14-cv-4822-JFL, 2015 WL 9872493 (E.D. Pa. Nov. 16, 2015) (emphasis added). The United States has maintained this position in two additional cases.[6]

83. Alternatively, gender dysphoria is not excluded under the ADA because it is *not* a "gender identity disorder" under 42 U.S.C. § 12211(b)(1)—it is a new and distinct diagnosis. In 2013, the DSM-5 replaced the diagnosis of "gender identity disorders" with gender dysphoria. This replacement was more than semantic; it reflects a substantive difference between the medical conditions themselves. Unlike the outdated diagnosis of gender identity disorder, the hallmark or presenting feature of gender dysphoria is not a person's gender identity. Rather, it is the clinically significant distress, termed dysphoria, that some people experience as a result of the mismatch between a person's gender identity and their assigned sex. Reflecting this distinction, the diagnostic criteria for gender dysphoria in the DSM-5 are different than those for gender identity disorder. Indeed, there are people with gender dysphoria that would not meet the criteria for gender identity disorder. Furthermore, the diagnosis of gender dysphoria rests upon a growing body of new scientific research showing that gender dysphoria has a physical cause. *See* DSM-5, *supra*, note 5 (discussing possible genetic and physiological underpinnings of gender dysphoria).

84. Alternatively, gender dysphoria is not excluded under the ADA because it is not a "gender identity disorder," as that term is used in 42 U.S.C. § 12211(b)(1). As the U.S. District Court for the Eastern District of Pennsylvania held in *Blatt v. Cabela's Retail, Inc.*, "gender identity disorder" in the ADA refers simply to transgender identity (i.e., "the condition of identifying with a different gender")—not to medical conditions like gender dysphoria that

[6] *See* Stat. of Int. of U.S. at 2-3, *Doe v. Dzurenda*, No. 3:16-CV-1934 (D. Conn. Oct. 27, 2017), ECF No. 57; Stat. of Int. of U.S. at 2-3, *Doe v. Arrisi*, No. 3:16-cv-08640 (D.N.J. July 17, 2017), ECF No. 49.

transgender people may have. *Blatt v. Cabela's Retail, Inc.*, 2017 WL 2178123, at *4 (E.D. Pa. 2017); *see id.* at 3 n.3 (likening "gender identity disorder" to "homosexual[ity] or bisexual[ity]," none of which are medical conditions covered by the ADA); *see also* Kevin Barry & Jennifer Levi, "*Blatt v. Cabela's Retail, Inc.* and a New Path for Transgender Rights," 127 YALE L.J. FORUM 373, 385 (2017) (discussing *Blatt*'s holding).

85. Mr. Musgrove's gender dysphoria substantially limits one or more major life activities, including his ability to care for himself, eating, sleeping, learning, concentrating, thinking, communicating, interacting with others, and reproducing, and also substantially limits the operation of major bodily functions, including neurological function, brain function, and reproductive function.

86. Mr. Musgrove has a record of gender dysphoria, which substantially limits one or more major life activities, including his ability to care for himself, eating, sleeping, learning, concentrating, thinking, communicating, interacting with others, and reproducing, and also substantially limits the operation of major bodily functions, including neurological function, brain function, and reproductive function.

87. Mr. Musgrove "meets the requirement of 'being regarded as having' an impairment that substantially limits one or more major life activities" because UGA and the Board have adopted a healthcare policy that excludes treatment for gender dysphoria, they have participated in a contractual or other arrangement or relationship with BCBS and MetLife that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Title I of the ADA, and they have adopted a healthcare policy that has the effect of discriminating on the basis of gender dysphoria, and that screens out or tends to screen out individuals with gender dysphoria.

88. Mr. Musgrove "meets the requirement of 'being regarded as having' an impairment that substantially limits one or more major life activities" because BCBS and MetLife have offered a healthcare policy that excludes treatment for gender dysphoria, they have participated in a contractual or other arrangement or relationship with UGA and the Board that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Title I of the ADA, and they have offered a healthcare policy that has the effect of discriminating on the basis of gender dysphoria, and that screens out or tends to screen out individuals with gender dysphoria.

89. As a result of Defendants' actions and failure to accommodate, Mr. Musgrove has been forced to either forego medically necessary treatment due to lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

SECOND CAUSE OF ACTION

Unlawful Discrimination on the Basis of Disability in Violation of Title II of the Americans with Disabilities Act
Against UGA and Board of Regents
(for compensatory damages, declaratory relief, and injunctive relief)

90. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

91. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity," 42 U.S.C. § 12132(a), including discrimination in the provision of "any aid, benefit, or service . . . directly or through contractual, licensing, or other arrangements, on the basis of disability . . . ." *Id.* at 12132(b); U.S. DEP'T OF JUSTICE, GUIDANCE ON ADA REGULATION ON NONDISCRIMINATION ON THE BASIS OF DISABILITY IN STATE AND LOCAL GOVERNMENT SERVICES ORIGINALLY

PUBLISHED JULY 26, 1991, 28 C.F.R. Pt. 35, App. B § 35.102 ("All governmental activities of public entities are covered, even if they are carried out by contractors.").

92. In particular, under Title II of the ADA, "[n]o qualified individual with a disability shall, on the basis of disability, be subjected to discrimination in employment under any service, program, or activity conducted by a public entity." 28 C.F.R. § 35.140(a); *see also Bledsoe v. Palm Beach County Soil and Water Conservation Dist.*, 133 F.3d 816, 822 (11th Cir. 1998) ("Title II of the ADA encompasses public employment discrimination.").

93. "The requirements of title I of the [ADA], as established by the regulations of the Equal Employment Opportunity Commission in 29 CFR part 1630," are applicable to employment discrimination by a public entity, provided that "the public entity is also subject to the jurisdiction of title I." 28 C.F.R. § 35.140(b)(1).

94. Under Title II of the ADA, a "public entity" means "any State or local government" or "any department, agency, special purpose district, or other instrumentality of a State or States or local government." 42 U.S.C. § 12131(1)(A)-(B).

95. UGA and the Board are "public entit[ies]" within the meaning of Title II of the ADA.

96. The requirements of Title I of the ADA and EEOC regulations implementing the ADA, as amended, are applicable to employment discrimination by UGA and the Board because these entities are "covered entit[ies]" subject to the jurisdiction of Title I of the ADA, as set forth above in Paragraph 18.

97. As set forth above in Paragraphs 77, UGA and the Board violated Title I of the ADA by discriminating against Mr. Musgrove on the basis of his disability.

98. As set forth above in Paragraph 79, Mr. Musgrove is a qualified individual under Title I of the ADA.

99. As set forth above in Paragraphs 85 to 88, Mr. Musgrove has a disability, gender dysphoria, within the meaning of the ADA, as amended. *See* 28 C.F.R. § 35.108 (Title II regulations interpreting definition of disability under ADA).

100. As a result of UGA's and the Board's actions and failure to accommodate, Mr. Musgrove has been forced to either forego medically necessary treatment due to lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

THIRD CAUSE OF ACTION

Unlawful Discrimination on the Basis of Disability in Violation of Title III of the Americans with Disabilities Act

Against Defendants BCBS and MetLife (declaratory relief, and injunctive relief)

101. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

102. Title III of the ADA provides that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." 42 U.S.C. § 12182.

103. Under Title III of the ADA, "insurance offices" whose operations affect commerce are places of public accommodation, 42 U.S.C. § 12181(7)(F), "and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer." U.S. DEP'T OF JUSTICE, ADA TITLE III TECHNICAL ASSISTANCE

MANUAL, COVERING PUBLIC ACCOMMODATIONS AND COMMERCIAL FACILITIES III-3.11000, https://www.ada.gov/taman3.html.

104. Title III of the ADA prohibits disparate treatment of an individual on the basis of disability, including, "directly or through contractual, licensing, or other arrangements": (i) denying an individual the opportunity "to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity" on the basis of disability; (ii) affording an individual the opportunity "to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals"; (iii) providing an individual "with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that provided to other individuals"; and (iv) "exclud[ing] or otherwise deny[ing] equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association." 42 U.S.C. § 12182(b)(1)(A), (E).

105. Title III of the ADA prohibits conduct that has a disparate impact on an individual on the basis of disability, including: (i) "directly or through contractual, licensing, or other arrangements, utiliz[ing] standards or criteria or methods of administration . . . that have the effect of discriminating on the basis of disability"; and (ii) imposing "eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered." *Id.* § 12182(b)(1)(D), (b)(2)(A)(i).

106. Title III of the ADA prohibits not making "reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations." *Id.* § 12182(b)(2)(A)(ii).

107. The ADA contains a safe-harbor provision which states, among other things, that the ADA does not "prohibit or restrict . . . an insurer . . . from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law." 42 U.S.C. § 12201(c); *see also* 28 C.F.R. § 36.212. The ADA's § 12201(c) safe-harbor is limited; it "shall not be used as a subterfuge to evade the purposes of [the ADA]." 42 U.S.C. § 12201(c).

108. As insurance offices whose operations affect commerce, BCBS and MetLife are places of public accommodation under Title III of the ADA.

109. BCBS and MetLife violated Title III of the ADA by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Offering directly, or through a contractual or other arrangement with UGA and the Board, a healthcare policy that excludes treatment for gender dysphoria.

b. Offering directly, or through a contractual or other arrangement with UGA and the Board, a healthcare policy that has the effect of discriminating on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably modify the healthcare policy to include treatment for gender dysphoria.

110. The safe-harbor provision does not apply to the actions of BCBS and MetLife because there is no actuarial basis to price surgeries for gender dysphoria separately from any other type of surgery. Alternatively, the actions of BCBS and MetLife are a subterfuge to evade the purposes of the ADA.

111. As set forth above in Paragraphs 85 to 88, Mr. Musgrove has a disability, gender dysphoria, within the meaning of the ADA, as amended. *See* 28 C.F.R. § 36.105 (Title III regulations interpreting definition of disability under ADA).

112. As a result of Defendants' actions and failure to modify, Mr. Musgrove has been forced to either forego medically necessary treatment due to lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

FOURTH CAUSE OF ACTION

Unlawful Discrimination on the Basis of Disability in Violation of Section 504 of the Rehabilitation Act

Against Defendants (for compensatory damages, declaratory relief, and injunctive relief)

113. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

114. Section 504 of the Rehabilitation Act ("Section 504") provides that "[n]o otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance," 29 U.S.C. § 794(a); *see* 28 C.F.R. §

42.503(a), including "discrimination in employment under any program or activity receiving Federal financial assistance," 28 C.F.R. § 42.510(a).

115. Under Section 504, a "qualified individual" means, with respect to employment, a person with a disability "who, with reasonable accommodation, can perform the essential functions of the job in question"; and, with respect to services, a person with a disability "who meets the essential eligibility requirements for the receipt of such services." 28 C.F.R. § 42.540(l).

116. Under Section 504, a "program or activity receiving Federal financial assistance" includes "a department, agency, special purpose district, or other instrumentality of a State or of a local government," "a college, university, or other postsecondary institution, or a public system of higher education," or "an entire corporation, partnership, or other private organization," which receives federal funds or "[a]ny other thing of value by way of grant, loan, contract or cooperative agreement." 29 U.S.C. § 794(b)(1); *see* 28 C.F.R. § 42.540(h).

117. Section 504 prohibits disparate treatment of a qualified individual with a disability, including, "directly or through contractual, licensing, or other arrangements": (i) "[d]eny[ing] a qualified handicapped person the opportunity accorded others to participate in the program or activity receiving Federal financial assistance"; (ii) "[d]eny[ing] a qualified handicapped person an equal opportunity to achieve the same benefits that others achieve in the program or activity receiving Federal financial assistance"; (iii) "[p]rovid[ing] different or separate assistance to handicapped persons or classes of handicapped persons than is provided to others unless such action is necessary to provide qualified handicapped persons or classes of handicapped persons with assistance as effective as that provided to others," 28 C.F.R. § 42.503(b)(1); (iv) "limit[ing], segregat[ing], or classify[ing] applicants or employees in any way that adversely affects their opportunities or status because of handicap"; and (v) "participat[ing] in a contractual or other

relationship that has the effect of subjecting qualified handicapped applicants or employees to discrimination," 28 C.F.R. § 42.510(a); *see also* 29 U.S.C. § 794(d) (stating that standards under Title I of the ADA shall apply to employment discrimination by federally-funded programs or activities).

118. Section 504 prohibits conduct that has a disparate impact on a qualified individual with a disability, including "utiliz[ing] criteria or methods of administration that either purposely or in effect discriminate on the basis of handicap" or "defeat or substantially impair accomplishment of the objectives of the recipient's program or activity with respect to handicapped persons." 28 C.F.R. § 42.503(b)(3).

119. Section 504 prohibits not making "reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate, based on the individual assessment of the applicant or employee, that the accommodation would impose an undue hardship on the operation of its program or activity." 28 C.F.R. § 42.511(a); *see also Alexander v. Choate*, 469 U.S. 287, 301 (U.S. 1985) ("[T]o assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made [under Section 504]").

120. Because the definition of disability under the ADA and Rehabilitation Act is identical, the expanded definition of "disability" under the ADAAA, as set forth above in Paragraphs 69 to 74 applies with equal force to both statutes. *Compare* 42 U.S.C. § 12102 (defining "disability"), *with* 29 U.S.C. §§ 705(9)(B), (20)(B) (cross-referencing ADA definition of "disability"); *see also* ADAAA, *supra*, §7 (conforming Section 504's definition of "disability" to definition of disability "in section 3 of the Americans with Disabilities Act of 1990").

121. Defendants are programs or activities that receive federal financial assistance and are therefore subject to Section 504.

122. UGA and the Board violated Section 504 by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Adopting a healthcare policy that excludes treatment for gender dysphoria, and participating in a contractual or other arrangement or relationship with BCBS and MetLife that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Section 504.

b. Adopting a healthcare policy that has the effect of discrimination on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably accommodate Mr. Musgrove by modifying the healthcare policy to include treatment for gender dysphoria.

123. BCBS and MetLife violated Section 504 by discriminating against Mr. Musgrove on the basis of his disability. The discrimination includes:

a. Offering a healthcare policy that excludes treatment for gender dysphoria, and participating in a contractual or other arrangement or relationship with UGA and the Board that has the effect of subjecting Mr. Musgrove to discrimination prohibited by Section 504.

b. Offering a healthcare policy that has the effect of discrimination on the basis of gender dysphoria, or that screens out or tends to screen out individuals with gender dysphoria; and

c. Failing to reasonably accommodate Mr. Musgrove by modifying the healthcare policy to include treatment for gender dysphoria.

124. Mr. Musgrove is a qualified individual under Section 504 because, with respect to employment, he can perform the essential functions of his job, with or without reasonable accommodation; and, with respect to insurance services, he meets the essential eligibility requirements for the receipt of such services.

125. As set forth above in Paragraphs 85 to 88 with respect to the ADA, Mr. Musgrove has a disability, gender dysphoria, within the meaning of Section 504.[7]

126. As set forth above in Paragraphs 82 to 84 with respect to the ADA, gender dysphoria is not excluded under Section 504.[8]

127. As a result of Defendants' actions and failure to accommodate, Mr. Musgrove has been forced to either forego medically necessary treatment due to lack of coverage or obtain uncovered treatment at great cost. Beyond the financial hardship this has caused, Mr. Musgrove has also suffered stress, anguish, and humiliation.

[7] *See, e.g.*, *Allmond v. Akal Sec., Inc.*, 558 F.3d 1312, 1316 n. 3 (11th Cir. 2009) (stating that the Rehabilitation Act and the ADA are governed by "the same standards" and therefore may be used "interchangeably"); *Gaylor v. Georgia Dept. of Natural Resources*, 2013 WL 4790158, at *7 (N.D. Ga. 2013) ("The pleading requirements for a cause of action under Title II of the ADA and § 504 of the RA are essentially the same.").

[8] After excluding "gender identity disorders not resulting from physical impairments" from the ADA in 1990, Congress passed an identical exclusion to the Rehabilitation Act two years later. *See* 29 U.S.C. § 705 (excluding "gender identity disorders not resulting from physical impairments"); H.R. REP. NO. 102-973, at 158 (1992) (Conf. Rep.) (discussing amendment to Rehabilitation Act).

FIFTH CAUSE OF ACTION

Unlawful Discrimination on the Basis of Sex in Violation of Title VII of the Civil Rights Act of 1964
Against Defendants Board of Regents, UGA, BCBS, and MetLife
(for compensatory damages, declaratory relief, and injunctive relief)

128. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

129. Title VII provides that employers may not "discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's . . . sex." 42 U.S.C. § 2000e-2(a)(1).

130. An employer-sponsored health plan is part of the "compensation, terms, conditions, or privileges of employment." 42 U.S.C. § 2000e-2(a)(1).

131. Discrimination on the basis of external sex characteristics, brain sex, changing sex characteristics, transgender status, and nonconformity with sex- or gender-based stereotypes is discrimination on the basis of "sex" under Title VII.

132. Plaintiff is an employee of UGA as that term is defined in Title VII, 42 U.S.C. § 2000e(f).

133. UGA is an employer as that term is defined in Title VII, 42 U.S.C. § 2000e-(b). In establishing the scope of health care coverage and administering that coverage, the Board, BCBS, and MetLife are agents of UGA under Title VII.

134. BCBS unlawfully participated in discriminatory employment practices by offering a policy that contained a transgender exclusion.[9]

[9] *See U.S. Equal Employment Opportunity Commission, EEOC Compliance Manual (2000), Section 2-III-B-2(b)* (noting specifically that an insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent).

135. BCBS unlawfully participated in the discriminatory employment practices by offering to provide the Board with a discriminatory plan, contracting to provide the Board with a discriminatory health plan and denying Mr. Musgrove's requests for medical coverage.[10]

136. MetLife unlawfully participated in discriminatory employment practices by offering a policy that contained a transgender exclusion.[11]

137. MetLife unlawfully participated in the discriminatory employment practices by offering to provide the Board with a discriminatory plan, contracting to provide the Board with a discriminatory health plan and, as discussed in further detail above, offering a plan that prevented Mr. Musgrove from applying for disability coverage, denying his future requests for disability insurance coverage.[12]

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[10] *See US. Equal Employment Opportunity Commission, EEOC Compliance Manual (2000), Section 2-lll-B-2(b)* (noting specifically that an "insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent."); *Tovar v. Essentia Health*, No. 16-3186, 2017 WL 2259632, at *5 (8th Cir. May 24, 2017) (recognizing that a third party administrator can be the source of a discriminatory plan document and be held liable under Section 1557 "notwithstanding the fact that [the employer] subsequently adopted the plan and maintained control over its terms").

[11] *See U.S. Equal Employment Opportunity Commission, EEOC Compliance Manual (2000), Section 2-III-B-2(b)* (noting specifically that an insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent).

[12] *See US. Equal Employment Opportunity Commission, EEOC Compliance Manual (2000), Section 2-lll-B-2(b)* (noting specifically that an "insurance company that provides discriminatory benefits to the employees of a law firm may be liable under the EEO statutes as the law firm's agent."); *Tovar v. Essentia Health*, No. 16-3186, 2017 WL 2259632, at *5 (8th Cir. May 24, 2017) (recognizing that a third party administrator can be the source of a discriminatory plan document and be held liable under Section 1557 "notwithstanding the fact that [the employer] subsequently adopted the plan and maintained control over its terms").

Discrimination *Because of* Sex

138. Just as an exclusion for all treatments of conditions that are disproportionately race- or ethnicity-based would be both race and disability discrimination, denying a class of care because it intends to change sex characteristics is literally discrimination *because of* sex.

139. Generally, all medically necessary treatment and disability leave is covered by the Health and Disability Plans. In the case of gender dysphoria, the motivation for the exclusion is rooted in sex-based concerns. The denial is stemming from a reluctance to let people change sex characteristics where the *purpose* of the treatment is to change sex characteristics. This is inherently related to and based on the patient's sex, and therefore prohibited discrimination.

Disparate Treatment of Transgender Employees

140. In 2012, the Equal Employment Opportunity Commission (EEOC) held that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination based on sex and such discrimination therefore violates Title VII." *Macy v. Dep't. of Justice*, E.E.O.C. App. No. 0120120821, 2012 WL 1435995, at *12 (Apr. 20, 2012). Furthermore, dozens of district courts—both within and outside of the circuits that have explicitly recognized sex discrimination claims by transgender people—have found that anti-transgender discrimination is unlawful sex discrimination.

141. By offering health and disability plans that explicitly exclude coverage for transgender care, the Board and UGA have made a decision to Plaintiff differently and provide him with lesser compensation and benefit options because he is transgender. The plans provide lesser coverage on their face on the basis of sex.

Disparate Impact on Transgender Employees

142. Only transgender people, people whose brain sex does not match their external sex characteristics at birth, access treatments for gender dysphoria. The sole reason these individuals access to this particular treatment is to change female characteristics into male ones and vice versa. The treatments themselves change sex characteristics.

143. The exclusion of such treatments does not impact non-transgender employees at all. They do not need access to this care and their out-of-pocket health care costs will not increase (nor will their compensation decrease) if this care is not provided. The only class of employees this exclusion impacts is transgender employees.

144. Transgender employees receive less compensation because they are not able to access medically necessary care through the insurance plan they pay into. The fact that transgender employees are not able to access medically necessary care while non-transgender employees have their medically necessary care covered evidences a disparate impact on a protected class. It impacts Plaintiff's compensation as well as his access to medical care in a way that does not affect his non-transgender co-workers.

Sex Stereotyping

145. In addition, transitioning sexes is the ultimate violation of sex stereotypes. It is assumed that people born with typical female sex characteristics are physically and mentally female and will live as women. Plaintiff, being a man who was born with typical female sex characteristics, does not conform to the stereotype that one's sex matches one's sex-based external anatomy at birth. The Board's transgender care exclusion is also therefore sex discrimination on the basis of sex stereotyping, which has long been prohibited under Title VII.

146. By excluding coverage for transgender-related care, the Board is effectively requiring Mr. Musgrove to pay the same amount as his non-transgender co-workers for insurance in exchange for less healthcare. This exclusion singles Mr. Musgrove out to receive less compensation than he would if he were not transgender, and there is no legitimate, nondiscriminatory basis for providing him with substandard benefits other than his status as someone who does not conform to the stereotypes associated with his external sex characteristics at birth. Therefore, the difference in coverage constitutes sex discrimination under Title VII.

SIXTH CAUSE OF ACTION

Unlawful Discrimination on the Basis of Sex in Violation of Title IX of the Educational Amendments of 1972
Against Defendants Board of Regents, UGA, Hull, Morehead and Elliott
(for compensatory damages, declaratory relief, and injunctive relief)

147. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

148. Under Title IX, 20 U.S.C. § 1681(a), and its implementing regulations, "[n]o person shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in employment … under any education program or activity operated by a recipient which receives Federal financial assistance." 34 C.F.R. § 106.51(a)(1) (Department of Education Title IX regulations). See also 7 C.F.R. § 15a.500(a)(1) (Department of Agriculture Title IX regulations); 45 C.F.R. § 86.51 (Department of Health and Human Services Title IX regulations).

149. Title IX's prohibition on discrimination "on the basis of sex" encompasses discrimination based on external sex characteristics, brain sex, changing sex characteristics, transgender status, and, nonconformity to sex- or gender-based stereotypes.

150. Title IX's prohibitions on sex discrimination extends to "rates of pay or other compensation," 34 C.F.R. § 106.54(a); 7 C.F.R. § 15a.500(b)(3); 45 C.F.R. § 86.54(a), and all "[f]ringe benefits available by virtue of employment, whether or not administered by the recipient," 34 C.F.R. § 106.51(b)(7); 7 C.F.R. § 15a.500(b)(7); 45 C.F.R. § 86.51(b)(7). Fringe benefits include medical, hospital or accident benefit policies or plans, and a recipient may not "[d]iscriminate on the basis of sex with regard to making fringe benefits available to employees." 34 CFR 106.56; 7 C.F.R. § 15a.525; 45 C.F.R. § 86.56. Furthermore, "[a] recipient shall not enter into any contractual or other relationship which directly or indirectly has the effect of subjecting employees or students to discrimination prohibited by this subpart, including relationships with … organizations providing or administering fringe benefits to employees of the recipient." 34 C.F.R. § 106.51(a)(3); 7 C.F.R. § 15a.500(a)(3); 45 C.F.R. § 86.51(3).

151. As federal funding recipients, Defendants UGA and the Board are subject to Title IX's prohibitions on sex- and gender-based discrimination against in employment, compensation, and fringe benefits.

152. Defendants, by adopting and enforcing a policy or practice of excluding "sex change" treatments under the Health Plan, have discriminated and continue to discriminate against Plaintiff in employment. He was and is denied the benefits of employment and excluded from full participation in the Health Plan. He receives lesser compensation than co-workers on the basis of sex because the Health Plan is less valuable to employees who require medical treatment to change sex characteristics. The existence of the "sex change" exclusion stigmatizes and demeans Plaintiff. Defendants have treated Plaintiff differently from other male and non-transgender employees based on the difference between his external sex characteristics and his brain sex, as well as his nonconformity to sex stereotypes, and thereby are denying him the full and equal participation in,

benefits of, and right to be free from discrimination in the employment-based educational opportunities offered by UGA and the Board on the basis of sex, in violation of Title IX.

153. Defendants, by adopting and enforcing a policy or practice of excluding "sex-change surgery" under the Disability Plan, have discriminated and continue to discriminate against Plaintiff in employment. He was and is denied the benefits of employment and excluded from full participation in the Disability Plan. He receives lesser compensation than co-workers on the basis of sex because the Disability Plan is less valuable to employees who require medical treatment to change sex characteristics. The existence of the "sex-change" exclusion stigmatizes and demeans Plaintiff. Defendants have treated Plaintiff differently from other male and non-transgender employees based on the difference between his external sex characteristics and his brain sex, as well as his nonconformity to sex stereotypes, and thereby are denying him the full and equal participation in, benefits of, and right to be free from discrimination in the employment-based educational opportunities offered by UGA and the Board on the basis of sex, in violation of Title IX.

154. Defendants offering even one employee benefit plan with a "sex change" exclusion stigmatizes Plaintiff on the basis of sex as well as prohibits him from enjoying the full-range of benefit choices afforded to employees who do not require surgery to change sex characteristics. Offering plans with such exclusions creates a hostile environment that denies, limits and interferes with Plaintiff's ability to participate in and benefit from his employment.

155. Plaintiff has been, and continues to be, injured by Defendants' discriminatory conduct and has suffered damages as a result.

SEVENTH CAUSE OF ACTION

Violation of 42 U.S.C. § 1983 Based on the Deprivation of Plaintiff's Rights Under the Equal Protection Clause of the Fourteenth Amendment Based on Disability
Against Defendants Hull, Morehead, and Elliott (for declaratory and injunctive relief)

156. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

157. Defendants Hull, Morehead, and Elliott are persons for purposes of 42 U.S.C. § 1983.

158. Defendants Hull, Morehead, and Elliott acting under color of state law, have violated Mr. Musgrove's rights under the Equal Protection Clause of the 14th Amendment by impermissibly discriminating against him on the basis of disability.

159. The healthcare policy adopted by Defendants Hull, Morehead, and Elliott discriminates on the basis of disability because, among other things, it excludes treatment for the medical condition of gender dysphoria.

160. Discrimination by Defendants Hull, Morehead, and Elliott is not narrowly tailored to further a compelling government interest.

161. Discrimination by Defendants Hull, Morehead, and Elliott is not substantially related to an important or exceedingly persuasive government interest.

162. Discrimination by Defendants Hull, Morehead, and Elliott is not rationally related to a legitimate government interest.

163. As a direct and proximate result of the discrimination described above and their failure to accommodate, Plaintiff has suffered injury and damages, inter alia, financial damages, mental pain and suffering, humiliation, mental anguish and emotional distress. Without injunctive relief from Defendants' discriminatory exclusion of coverage for gender dysphoria treatments,

Plaintiff will continue to suffer irreparable harm in the future, including lack of access to medical treatment.

EIGHTH CAUSE OF ACTION

Violation of 42 U.S.C. § 1983 Based on the Deprivation of Plaintiff's Rights Under the Equal Protection Clause of the Fourteenth Amendment Based on Sex

Against Defendants Hull, Morehead, and Elliott (for declaratory and injunctive relief)

164. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

165. The Equal Protection Clause of the Fourteenth Amendment to the United States Constitution prohibits the states and state actors from discriminating against individuals based on their sex.

166. Discrimination on the basis of external sex characteristics, brain sex, changing sex characteristics, transgender status, and nonconformity to sex- or gender-based stereotypes is discrimination on the basis of sex.

167. The healthcare policy adopted by Defendants Hull and Morehead discriminates on the basis of sex because, among other things: (i) the healthcare policy excludes treatments undertaken for the purpose of treating gender dysphoria, a medical condition that applies only to transgender people—i.e., those whose affirmed sex does not align with their assigned sex at birth—and therefore discriminates based on sex; and (ii) the healthcare policy excludes treatment that alters physical characteristics that—along with brain sex—comprise and define one's sex, i.e., hormone levels, genital appearance, reproductive organs, and secondary sex characteristics such as breasts.

168. Discrimination on the basis of sex is a quasi-suspect class and demands a heightened level of scrutiny.

169. As a direct and proximate result of the discrimination described above, Plaintiff has suffered injury and damages, inter alia, financial damages, mental pain and suffering, humiliation, mental anguish and emotional distress. Without injunctive relief from Defendants' discriminatory exclusion of coverage for gender dysphoria treatments, Plaintiff will continue to suffer irreparable harm in the future, including lack of access to medical treatment.

NINTH CAUSE OF ACTION

Violation of 42 U.S.C. § 1983 Based on the Deprivation of Plaintiff's Rights Under the Equal Protection Clause of the Fourteenth Amendment Based on Transgender Status
Against Defendants Hull, Morehead, and Elliott (for declaratory and injunctive relief)

170. Plaintiff incorporates and realleges each and every allegation in the preceding paragraphs of this Complaint.

171. The healthcare policy adopted by Defendants Hull and Morehead discriminates on the basis of transgender status because, among other things, it excludes treatment for the purpose of changing sex characteristics, treatment that applies only to transgender people.

172. Discrimination on the basis of transgender status is suspect and demands a heightened level of scrutiny under the United States Constitution. Defendants' actions purposefully single out a minority group (transgender people) that historically have suffered discriminatory treatment and been relegated to a position of political powerlessness solely on the basis of stereotypes and myths regarding their transgender status—a characteristic that bears no relation to their ability to contribute to society and is immutable in that it is central to their core identity.

173. As a direct and proximate result of the discrimination described above, Plaintiff has suffered injury and damages, inter alia, financial damages, mental pain and suffering, humiliation, mental anguish and emotional distress. Without injunctive relief from Defendants' discriminatory

exclusion of coverage for gender dysphoria treatments, Plaintiff will continue to suffer irreparable harm in the future, including lack of access to medical treatment.

REQUEST FOR RELIEF

WHEREFORE, Plaintiff Skyler Musgrove respectfully requests that this Court:

A. Declare that the actions of Defendants complained of herein on their face and as applied to Plaintiff violate the ADA, Section 504, Title VII, Title IX and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution;

B. Issue preliminary and permanent injunctions enjoining any further enforcement or application of the exclusion for treatments of gender dysphoria in disability or health plans and directing Defendants to provide coverage for all medically necessary pharmaceutical and surgical treatments that have been or will be sought by Plaintiff for the treatment of gender dysphoria, including health care treatments and procedures that are consistent with the applicable standards of care for gender dysphoria;

C. Award compensatory and consequential damages in an amount to be determine at trial, as permitted under the ADA, Section 504, Title VII, Title IX, in an amount that would fully compensate Plaintiff for the harm to his short- and long-term health and well-being, the emotional distress he has suffered from being denied coverage for medically necessary health care as a result of the exclusion and its application to him, his economic losses, and all other damages that have been caused by Defendants' acts and omissions alleged in this Complaint;

D. Award punitive damages for violation of Title VII;

E. Award pre-judgment and post-judgment interest at the highest lawful rate;

F. Award Plaintiffs their reasonable attorneys' fees, costs, and expenses under 42 U.S.C. § 1988 or other applicable statutes; and

G. Award Plaintiff such other and further relief as the Court may deem just and proper.

Respectfully submitted this 28th day of June, 2018.

/s/ Amanda A Farahany
Amanda A. Farahany
Georgia Bar No. 646135
Anton Sorkin*
BARRETT & FARAHANY
1100 Peachtree Street NE, Suite 500
Atlanta, Georgia 30309-4501
T: (404) 214-0120
F: (404) 214-0125
amanda@justiceatwork.com
anton@justiceatwork.com

Noah Lewis*
TRANSCEND LEGAL
3553 82nd Street, #6D
Jackson Heights, New York 11372-5148
T: (347) 612-4312
F: (347) 990-1781
nlewis@transcendlegal.org

* *Pro hac vice motion to follow*

Exhibit E

BlueCross BlueShield of Georgia

#FGA673357M19/DS0# M005
3075 VANDERCAR WAY
CINCINNATI, OH 45209

(800) 424-8950
TOLL FREE (800) 424-8950

#BWNCQXF
#FGA673357M19/DS0# M005
SKYLER MUSGROVE
[redacted]
ATHENS GA 30605[redacted]

DEAR SKYLER MUSGROVE

To get the most from your benefits, you need to understand how your plan works. The enclosed Explanation of Benefits(EOB) will help you do this. **This is not a bill.** Instead, it is a summary of how Blue Cross and Blue Shield of Georgia processed a recent claim.

The enclosed EOB is in accordance with your Blue Cross and Blue Shield of Georgia benefits and includes detailed claim information. This includes the amount you saved by choosing a provider in the Blue Cross and Blue Shield of Georgia network (Provider Responsibility). It also includes the amount you may owe in addition to your copayment, deductible and coinsurance (Additional Member Responsibility).

This claim was processed in the order it was received from your provider, not in the order you received the service. Claims for multiple providers may have been processed separately. If you have coverage through more than one health plan, you should notify each plan and file all your claims with them to ensure correct payment.

If you have any questions, we encourage you to call the customer service number listed on the back of your Blue Cross and Blue Shield of Georgia ID card.

For more information, don't forget that **BCBSGA.com** is open all night for your convenience!

Register at ***www.bcbsga.com*** today to view claims information, order ID cards and use WebMD. Learn more about health care and healthy habits, 24/7. Check out Special Offers for discounts on services like Jenny Craig and eyewear at Lenscrafters.

Thank you for choosing Blue Cross and Blue Shield of Georgia!

Claims Department
Blue Cross and Blue Shield of Georgia

Appealing a decision (NON ERISA MEMBERS)

Your Right to Appeal

If you disagree with a claim decision made by Blue Cross and Blue Shield of Georgia regarding coverage of care or services recommended by your physician, you have the right to appeal. A physician or member representative may act on your behalf in all appeals.

How to Initiate an Appeal

Submit the appeal verbally or in writing within 180 calendar days from the receipt date of the adverse benefit determination notification. Appeals may be submitted verbally or in writing, via mail or fax, and may include written comments, records and other information relating to your appeal. You may contact the Plan using the information listed below for both a verbal and written appeal request.

All written appeals should include:
* The member's name and member's Health Care Identification number.
* The actual service for which coverage was requested.
* The reasons why you feel the coverage decision should be reconsidered.
* Any available medical information to support your reasons.

The Appeal Process

A physician or appropriate individual that did not participate in the original decision and is not a subordinate of the original decisionmaker will review your appeal. For Urgent Care claims, the claims administrator will respond within 72 hours from the date the Plan receives your appeal request. For non-urgent claims, the claims administrator will respond within 30 calendar days from the date the Plan receives your appeal request. The notification response will include reasons for the decision and references to plan provisions on which the decision was based.

Questions

If you have any questions about your right to appeal or about how to file an appeal, please call our Customer Care Center using the number listed on the back of your member ID card.

ASO Expedited Appeal Rights

If you are a member of a non-grandfathered health plan, as defined by the Patient Protection and Affordable Care Act(PPACA), you may request an expedited external review instead of, or at the same time as, exercising the expedited appeal process with your plan. To request an expedited external review, you, your provider or your representative can contact customer service at the telephone number on your ID card. If you prefer, you may send your written request, and any additional supporting documentation, to the following address:P.O.BOX 54159, Los Angeles CA 90054.

ASO External Review Rights

If we deny your appeal, you will be provided with other dispute resolution options as applicable. If you are a member of a non-grandfathered health plan, as defined by PPACA, you may have the right to request an independent external review of our decision. Please refer to your description of benefits or contact customer service at the telephone number on your ID card for detailed information regarding the entire appeal process.

THIS IS NOT A BILL

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

CHECK NUMBER:	NA
PATIENT:	MUSGROVE,SKYLER
PATIENT ACCOUNT #:	UNKNOWN
INSURED ID:	[redacted]0236
PROVIDER:	HOPE SHERIE
CLAIM #:	2017270496151
PROVIDER PARTICIPATION STATUS	OUT OF NETWORK
CLAIM RECEIVED DATE:	09/27/2017
EOB DATE:	10/10/2017
AMOUNT PROVIDER MAY BILL YOU, IF NOT ALREADY PAID	8,333.32

YOUR BENEFIT SNAPSHOT*

BENEFIT YEAR 2017	BENEFIT AMOUNT	AMOUNT MET-YEAR TO DATE	REMAINING BALANCE
INDIVIDUAL IN-NETWORK DEDUCTIBLE	2,000.00	0.00	2,000.00
INDIVIDUAL OUT-OF-NETWORK DEDUCTIBLE	4,000.00	0.00	4,000.00
FAMILY-IN-NETWORK DEDUCTIBLE	4,000.00	0.00	4,000.00
FAMILY OUT-OF-NETWORK DEDUCTIBLE	8,000.00	0.00	8,000.00
INDIVIDUAL IN-NETWORK OUT-OF-POCKET-LIMIT	3,500.00	0.00	3,500.00
INDIVIDUAL OUT-OF-NETWORK OUT-OF-POCKET-LIMIT	7,000.00	0.00	7,000.00
FAMILY-IN-NETWORK OUT-OF-POCKET-LIMIT	7,000.00	0.00	7,000.00
FAMILY OUT-OF-NETWORK OUT-OF-POCKET-LIMIT	14,000.00	0.00	14,000.00

Medical Necessity reviews for your health benefit plan are performed under the Anthem UM Services, Inc. license.

MUSGROVE,SKYLER APT 205 ATHENS GA 30605

DATE(S) OF SERVICE	CODES	TYPE OF SERVICE	CHARGE	ALLOWABLE AMOUNT	PROVIDER RESPONSIBILITY	REASON CODE(S)	DEDUCTIBLE	COPAY/ COINSURANCE	ADDITIONAL MEMBER RESPONSIBILITY	REASON CODE(S)	AMOUNT PAID TO PROVIDER
05/30/2017-05/30/2017	19303	SURGERY-BREAST	8,333.32	0.00	0.00		0.00	0.00 / 0.00	8,333.32	001	0.00
TOTALS			8,333.32	0.00	0.00		0.00	0.00	8,333.32		0.00

YOU CAN LEARN MORE ABOUT THE SERVICES LISTED BY CALLING THE CUSTOMER SERVICE PHONE NUMBER ON THE BACK OF YOUR ID CARD. WE CAN TELL YOU THE DIAGNOSIS AND TREATMENT CODES INCLUDED ON YOUR CLAIM, ALONG WITH THE DESCRIPTIONS FOR THOSE CODES.

THIS PRODUCT IS ADMINISTERED BY BLUE CROSS BLUE SHIELD HEALTHCARE PLAN OF GEORGIA(BCBSHP). BCBSHP PROVIDES ADMINISTRATIVE CLAIMS PAYMENT SERVICES ONLY AND ASSUMES NO FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS. BLUE CROSS AND BLUE SHIELD OF GEORGIA INC(BCBSGA) AND BCBSHP ARE INDEPENDENT LICENSEES OF THE BLUE CROSS BLUE SHIELD ASSOCIATION. THE BLUE CROSS AND BLUE SHIELD NAMES AND SYMBOLS ARE REGISTERED MARKS OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION.

REASON CODE	REASON CODE TEXT
001	THIS IS NOT A COVERED EXPENSE OF THE PATIENT'S PLAN.

Exhibit F

Blue Cross Blue Shield of Georgia
Grievances and Appeals
P.O. Box 105449
Atlanta, GA 30348-5449

BlueCross BlueShield of Georgia

April 24, 2018

SKYLER MUSGROVE
[redacted]
VALDOSTA, GA, 31602-0000

Case number:	0513060704
Member name:	Skyler Musgrove
Member ID number:	462M80236
Date appeal received:	April 12, 2018

Claim Number(s)	Provider(s)/Facility	Date(s) of Service	Claim Amount(s)
2017270496151	Sherie Hope	May 30, 2017	$8,333.32

Dear Skyler Musgrove:

I've finished reviewing the appeal from Transcend Legal for services performed on May 30, 2017. I understand an appeal was requested because you would like the denied charges to process at your in-network benefit level. The previous coverage decision is being upheld.

I have reviewed and verified the coding and processing of the claim. I have determined that the claim has denied correctly per the terms and conditions of your Open Access POS contract. Board of Regents is a self-insured account with us, which means we have a fiduciary responsibility to administer their contract benefits and have no flexibility in overriding the benefits they have chosen for their members. According to the "What's Not Covered" section of your Certificate Booklet, this plan does not cover any item, service, supply or care not specifically listed as a Covered Service in this Contract.

Your Explanation of Benefits (EOB) has details about your claim. If you don't have a copy of your EOB, you can get one by calling customer service at the phone number on your member ID card. You also can call customer service or visit www.bcbsga.com for details about your EOB or claim.

ERISA Rights

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), once you have exhausted all mandatory appeal rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA.

Sincerely,
Clarence B.
Clarence B.
Grievances and Appeals Analyst
Grievances and Appeals

Enclosure:
Rights Available to Members

cc: Noah E. Lewis, ESQ.
3553 82nd St. #6d
Jackson Heights, NY 11372

Rights Available to Members

You may ask for and get copies of all documents including the actual benefit provision, guideline, protocol or other similar criterion on which this decision was based. Send a written request to Grievances and Appeals, P.O. Box 105449, Atlanta, GA 30348-5449. Or, call customer service at the phone number on your member ID card. Copies are free.

You may ask for the diagnosis and treatment codes that are the subject of the appeal. You may also ask for a description of these codes, if available. Call customer service at the phone number on your member ID card.

If I don't agree with this decision, what other rights do I have?

You may ask for a voluntary second level appeal. You have 60 days from the date you get this letter to ask for this appeal. Unless your benefits booklet states otherwise, your request must be in writing to our address above.

Independent external review is available if our decision was based on medical judgment as provided by the Patient Protection and Affordable Care Act (PPACA). If eligible for an independent external review, there is no cost to you. Independent external review is separate from the voluntary second level appeal described above. You don't have to ask for a voluntary second level appeal prior to asking for an independent external review. However, you won't be able to ask for a voluntary second level appeal after an independent external review. You have four months from the date you get this letter to ask for an independent external review. Your request must be in writing to our address above.

Other resources to help you

An Office of Health Insurance Consumer Assistance or Ombudsman Program may be available to help you if you have questions or concerns about your coverage or the grievance and appeal rights available to you.

Exhibit G

BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA

HUMAN RESOURCES
270 WASHINGTON STREET, S.W.
ATLANTA, GEORGIA 30334

February 12, 2018

Noah E. Lewis, Esq.
Executive Director
Transcend Legal
291 Crown St. #D8
Brooklyn, NY 11225-3031

Dear Noah Lewis, Esq.

We are in receipt of your appeal request on behalf of Skylar Musgrove, for transgender health related coverage under the University System of Georgia Blue Cross and Blue Shield self-insured health care plans.

University System of Georgia offers three self-insured health care plans with Blue Cross and Blue Shield of Georgia and one fully-insured HMO plan with Kaiser Permanente for all benefits eligible employees in the system. Our self-insured plans are not subject to the coverage requirements of fully insured health care plans.

While we believe that the USG plans are comprehensive in their coverage, consistent with federal law there are a number of services or treatments that are not covered by the plan at this time, including but not limited to transgender related services and procedures. However, coverage for transgender and reassignment services are available under the Kaiser HMO health care plan. Should you decide to consider this plan, you have the option to enroll in the Kaiser HMO plan for the 2018 plan year.

Each year, we partner with our Total Rewards Steering Committee, comprised of USG faculty, staff and retirees with expertise in health care plan management, to evaluate changes to our healthcare plans for the upcoming plan year. We will continue to assess Section 1557, of the ACA as it pertains to healthcare plan coverage requirements and coverage for transgender and reassignment services. At this time, coverage for transgender and reassignment services are not available under our Blue Cross and Blue Shield self-insured health care plans.

As with any new benefit offerings and plan changes, we will communicate these changes to USG employees and HR practitioners.

Sincerely,

Karin Elliott

Karin Elliott
Interim Vice Chancellor – Human Resources

JS 44 (Rev. 06/17)

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

Skylar Musgrove

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

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

Amanda A. Farahany, Barrett & Farahany
1100 Peachtree Street, Suite 500, Atlanta, GA 30309 (404) 214-0120

DEFENDANTS

Board of Regents of the University System of Georgia, 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)*

Click here for: Nature of Suit Code Descriptions.

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

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

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

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

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark

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

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

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

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

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 - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
ADA, Title VII, Title IX, Section 504

Brief description of cause:
Complaint for discrimination on the basis of disability, sex and transgender status.

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
06/28/2018

SIGNATURE OF ATTORNEY OF RECORD
s/ Amanda A. Farahany

FOR OFFICE USE ONLY

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

Print Save As... Reset

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading 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. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. **Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441. When the petition for removal is granted, check this box.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statue.

VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service

VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Middle District of Georgia

Skylar Musgrove *Plaintiff(s)*	)	
v.	)	Civil Action No.
Board of Regents of the University System of Georgia, et al. *Defendant(s)*	)	

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* THE BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA
270 Washington Street, SW
Atlanta, GA 30334

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Amanda A. Farahany
Barrett & Farahany
1100 Peachtree Street, Suite 500
Atlanta, GA 30309

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____

was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____

_____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____

_____ , a person of suitable age and discretion who resides there,

on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is

designated by law to accept service of process on behalf of *(name of organization)* _____

_____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____

Server's signature

_____

Printed name and title

_____

Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Middle District of Georgia

Skylar Musgrove *Plaintiff(s)*	)	
v.	)	Civil Action No.
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CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

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❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

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Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Middle District of Georgia

Skylar Musgrove *Plaintiff(s)*	)	
v.	)	Civil Action No.
Board of Regents of the University System of Georgia, et al. *Defendant(s)*	)	

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Atlanta, GA 30334

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Barrett & Farahany
1100 Peachtree Street, Suite 500
Atlanta, GA 30309

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CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

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❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

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I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Middle District of Georgia

Skylar Musgrove *Plaintiff(s)*	)	
v.	)	Civil Action No.
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1100 Peachtree Street, Suite 500
Atlanta, GA 30309

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

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Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

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_____ , a person of suitable age and discretion who resides there,

on *(date)* _____ , and mailed a copy to the individual's last known address; or

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designated by law to accept service of process on behalf of *(name of organization)* _____

_____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____

Server's signature

_____

Printed name and title

_____

Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Middle District of Georgia

Skylar Musgrove *Plaintiff(s)*	)	
v.	)	Civil Action No.
Board of Regents of the University System of Georgia, et al. *Defendant(s)*	)	

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* THE BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA
270 Washington Street, SW
Atlanta, GA 30334

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: Amanda A. Farahany
Barrett & Farahany
1100 Peachtree Street, Suite 500
Atlanta, GA 30309

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____

was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____

_____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____

_____ , a person of suitable age and discretion who resides there,

on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is

designated by law to accept service of process on behalf of *(name of organization)* _____

_____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____

Server's signature

_____

Printed name and title

_____

Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Middle District of Georgia

Skylar Musgrove *Plaintiff(s)*	)	
v.	)	Civil Action No.
Board of Regents of the University System of Georgia, et al. *Defendant(s)*	)	

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Date: _____

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Signature of Clerk or Deputy Clerk

Civil Action No.

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AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Middle District of Georgia

Skylar Musgrove *Plaintiff(s)*	)	
v.	)	Civil Action No.
Board of Regents of the University System of Georgia, et al. *Defendant(s)*	)	

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Atlanta, GA 30309

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Signature of Clerk or Deputy Clerk

Civil Action No.

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❒ I served the summons on *(name of individual)* _____ , who is

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AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Middle District of Georgia

Skylar Musgrove *Plaintiff(s)*	)	
v.	)	Civil Action No.
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