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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona; Arizona Board of Regents, d/b/a University of Arizona, a governmental body of the State of Arizona; **Ron Shoopman,** In his official capacity as Chair of the Arizona Board of Regents; **Larry Penley,** in his official capacity as member of the Arizona Board of Regents; **Ram Krishna,** in his official capacity as Secretary of the Arizona Board of Regents; **Bill Ridenour,** in his official capacity as treasurer of the Arizona Board of Regents; **Lyndel Manson,** in her official capacity as member of the Arizona Board of Regents; **Karrin Taylor Robson,** in her official capacity as member of the Arizona Board of Regents; **Jay Heiler,** in his official capacity as member of the Arizona Board of Regents; **Fred Duval**, in his official capacity as member of the Arizona Board of Regents; **Andy Tobin**, in his official capacity as Director of the Arizona Department of Administration; **Paul Shannon**, in his official capacity as Acting Assistant Director of the Benefits Services Division of the Arizona Department of Administration,

Defendants.

CV 19-0035-TUC-RM (LAB)

AMENDED COMPLAINT

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Plaintiff Russell B. Toomey, Ph.D., on behalf of himself and all others similarly situated, brings this action against Defendants State of Arizona, Arizona Board of Regents, d/b/a University of Arizona, Ron Shoopman, Larry Penley, Ram Krishna, Bill Ridenour, Lyndel Manson, Karrin Taylor Robson, Jay Heiler, Fred DuVal, Andy Tobin, and Paul Shannon, for violations of Title VII of the Civil Rights Act of 1964 and the Equal Protection Clause of the Fourteenth Amendment.

INTRODUCTION

1. The State of Arizona provides healthcare coverage to State employees through a self-funded health plan controlled by the Arizona Department of Administration ("the Plan"). (Exhibit A.)

2. The Plan generally provides coverage for medically necessary care, but singles out transgender employees for unequal treatment by categorically denying all coverage for "[g]ender reassignment surgery" regardless of whether the surgery qualifies as medically necessary treatment. As a result, transgender individuals enrolled in the Plan have no opportunity to demonstrate that their transition-related care is medically necessary, and they have no opportunity to appeal any adverse determination to an independent reviewer.

3. In the past, some public and private insurance companies excluded coverage for treatment of gender dysphoria (also called "transition-related care" or "gender-affirming care"), including surgical treatments, based on the erroneous assumption that such treatments were cosmetic or experimental. Today, however, every major medical organization to address the issue has recognized that such exclusions have no basis in medical science and that transition-related care is effective, safe and medically necessary for treatment of gender dysphoria.

4. Plaintiff Russell B. Toomey, Ph.D., is a man who is transgender. He is employed as an Associate Professor at the University of Arizona. As a result of the Plan's

discriminatory exclusion, Dr. Toomey has been blocked from receiving a medically-necessary hysterectomy prescribed by his physician in accordance with the widely accepted standards of care for treating gender dysphoria. The Plan provides coverage for the same hysterectomies when prescribed as medically necessary treatment for other medical conditions. But, the Plan categorically excludes coverage for hysterectomies when they are medically necessary for purposes of "[g]ender reassignment."

5. If the discriminatory exclusion were removed, Dr. Toomey would have an opportunity to prove that his surgery is medically necessary under the Plan's generally applicable standards for establishing medical necessity.

6. If the discriminatory exclusion were removed, Dr. Toomey would also have the right to appeal any adverse determination to an independent reviewer within the third-party claims administrator and, if necessary, to an independent review organization.

7. On its face, the Plan discriminates against Dr. Toomey and other transgender employees "because of . . . sex" in violation of Title VII of the Civil Rights Act of 1964 and deprives Dr. Toomey and other transgender employees of equal treatment under the Equal Protection Clause of the Fourteenth Amendment.

8. Dr. Toomey brings this Amended Complaint on behalf of himself and a proposed class of similarly situated individuals for declaratory and injunctive relief requiring Defendants to remove the Plan's categorical exclusion of coverage for "[g]ender reassignment surgery" and evaluate whether transgender individuals' surgical care for gender dysphoria is "medically necessary" in accordance with the Plan's generally applicable standards and procedures.

JURISDICTION AND VENUE

9. This action arises under Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq*. ("Title VII"), the Constitution of the United States, and 42 U.S.C. § 1983.

10. This 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).

11. Declaratory relief is authorized by 28 U.S.C. §§ 2201 and 2202.

12. Venue lies with this Court pursuant to 42 U.S.C. § 2000e-5(f)(3) because the unlawful employment practice was committed in the State of Arizona.

PARTIES

13. Plaintiff Russell B. Toomey, Ph.D., resides in Tucson, Arizona.

14. Dr. Toomey is employed by Defendant, the Arizona Board of Regents, as an Associate Professor at the University of Arizona.

15. The Arizona Board of Regents provides healthcare to its employees, including Dr. Toomey, through a self-funded plan controlled by the Arizona Department of Administration.

16. Defendant Ron Shoopman is sued in his official capacity as Chair of the Arizona Board of Regents.

17. Defendant Ram Krishna is sued in his official capacity as Secretary of the Arizona Board of Regents.

18. Defendant Bill Ridenour is sued in his official capacity as Treasurer of the Arizona Board of Regents.

19. Defendants Larry Penley, Lyndel Manson, Karrin Taylor Robson, Jay Heiler, and Fred DuVal are sued in their official capacities as Members of the Arizona Board of Regents.

20. Defendant Andy Tobin is sued in his official capacity as Interim Director of the Arizona Department of Administration.

21. Defendant Paul Shannon is sued in his official capacity as Acting Assistant Director of the Benefits Services Division of the Arizona Department of Administration.

EXHAUSTION OF ADMINISTRATIVE REQUIREMENTS

22. On August 15, 2018, Dr. Toomey timely filed a charge with the Equal Employment Opportunity Commission against the Arizona Board of Regents for sex discrimination in violation of Title VII.

23. On December 14, 2018, the Department of Justice issued a right-to-sue letter to Dr. Toomey, which was received on December 27, 2018. (Exhibit B.)

FACTUAL ALLEGATIONS

Transgender individuals and gender dysphoria

24. Gender identity is a well-established medical concept, referring to one's sense of oneself as belonging to a particular gender. Typically, people who are designated female at birth based on their external anatomy identify as girls or women, and people who are designated male at birth identify as boys or men. For transgender individuals, however, the sense of one's gender identity differs from the sex assigned to them at birth.

25. Transgender men are men who were assigned "female" at birth, but have a male gender identity. Transgender women are women who were assigned "male" at birth, but have a female gender identity.

26. Although the precise origins of each person's gender identity is not fully understood, experts agree that it likely results from a combination of biological factors as well as social, cultural, and behavioral factors.

27. Being transgender is not a mental disorder. Men and women who are transgender have no impairment in judgment, stability, reliability, or general social or vocational capabilities solely because of their transgender status. But transgender men and women may require treatment for "gender dysphoria," the diagnostic term for the clinically significant emotional distress experienced as a result of the incongruence of one's gender with their assigned sex and the physiological developments associated with that sex. The criteria for diagnosing gender dysphoria are set forth in the Diagnostic and Statistical

Manual of Mental Disorders (DSM-V) (302.85).

28. The widely accepted standards of care for treating gender dysphoria are published by the World Professional Association for Transgender Health ("WPATH"). Under the WPATH standards, medically necessary treatment for gender dysphoria may require medical steps to affirm one's gender identity and transition from living as one gender to another. This treatment, often referred to as transition-related care or gender-affirming care, may include hormone therapy, surgery (sometimes called "sex reassignment surgery" or "gender confirmation surgery"), and other medical services that align individuals' bodies with their gender identities.

29. Under the WPATH standards, the exact medical treatment varies based on the individualized needs of the person. Under each patient's treatment plan, the goal is to enable the individual to live all aspects of their life consistent with their gender identity, thereby eliminating the distress associated with the incongruence.

30. In the past, public and private insurance companies excluded coverage for transition-related care based on the assumption that such treatments were cosmetic or experimental. Today, however, transition-related surgical care is routinely covered by private insurance programs. The American Medical Association, the American Psychological Association, the American Psychiatric Association, the American College of Obstetricians and Gynecologists, and every other major medical organization have issued policy statements and guidelines supporting healthcare coverage for transition-related care as medically necessary under contemporary standards of care. No major medical organization has taken the position that transition-related care is not medically necessary or advocated in favor of a categorical ban on insurance coverage for transition-related procedures.

31. Medicare began covering transition-related surgery in 2014 after an independent medical board in the U.S. Department of Health & Human Services rescinded

an old Medicare policy that had excluded surgery from Medicare coverage. The decision explained that the Medicare surgery exclusion was based on a medical review conducted in 1981 and failed to take into account subsequent developments in surgical techniques and medical research. Medicare now provides coverage for transition-related surgical care for gender dysphoria on a case-by-case basis based on individualized medical need.

The Self-Funded Health Plan's "Gender Reassignment" Exclusion

32. Dr. Toomey's healthcare coverage is provided and paid for by the State of Arizona through the Plan.

33. Individuals enrolled in the Plan must choose to receive benefits through a Network Provider. In 2018, the four Network Providers were Aetna, Blue Cross Blue Shield of Arizona, Cigna, and UnitedHealthcare. Dr. Toomey's Network Provider is Blue Cross Blue Shield of Arizona.

34. The Plan generally provides coverage for medically necessary care, which the Plan defines as "services, supplies and prescriptions, meeting all of the following criteria": (1) ordered by a physician; (2) not more extensive than required to meet the basic health needs; (3) consistent with the diagnosis of the condition for which they are being utilized; (4) consistent in type, frequency and duration of treatment with scientifically based guidelines by the medical-scientific community in the United States of America; (5) required for purposes other than the comfort and convenience of the patient or provider; (6) rendered in the least intensive setting that is appropriate for their delivery; and (7) have demonstrated medical value.

35. In the event that the Plan denies coverage for a treatment based on purported lack of medical necessity, the Plan provides a right to appeal the decision to an independent reviewer at the third-party claims administrator and, if necessary, to further appeal to an external independent review organization. If an independent reviewer concludes that the treatment is medically necessary, that decision is binding, and the Plan must immediately

authorize coverage for the treatment.

36. The Plan does not apply these generally applicable standards and procedures to surgical care for gender dysphoria. Instead, the Plan categorically denies all coverage for "[g]ender reassignment surgery" regardless of whether the surgery qualifies as medically necessary. Transgender individuals enrolled in the Plan have no opportunity to demonstrate that their transition-related care is medically necessary or to appeal any adverse determination to an independent reviewer.

37. All four of the health insurance companies who serve as Network Providers for the Plan have adopted internal policies and standards for determining when transition-related surgery for gender dysphoria is medically necessary and, thus, covered. (Exhibits C-F) But, as a result of the Plan's "gender reassignment" exclusion, the Network Providers do not apply those internal policies and standards when administering the Plan to Arizona State employees and, instead, automatically deny coverage of transition-related surgery.

Dr. Toomey's medically necessary treatment for gender dysphoria

38. Dr. Toomey is a man who is transgender, which means that he has a male gender identity, but the sex assigned to him at birth was female. Dr. Toomey transitioned to live consistently with his male identity in 2003. Since 2003, Dr. Toomey has received testosterone as a medically necessary treatment for gender dysphoria. He also received medically necessary chest reconstruction surgery in 2004.

39. In accordance with the WPATH Standards of Care, Dr. Toomey's treating physicians have recommended that he receive a hysterectomy as a medically necessary treatment for gender dysphoria.

40. The Plan provides coverage for the same surgery when prescribed as medically necessary treatment for other medical conditions, but not when the surgery is performed as part of transition-related care.

41. Dr. Toomey has satisfied all of the criteria for a medically necessary hysterectomy under the WPATH Standards of Care.[1]

42. All four of the Network Providers for the Plan have adopted internal policies and guidelines that authorize hysterectomies as medically necessary treatments for gender dysphoria based on the same criteria used by the WPATH Standards of Care.

43. As a result of the Plan's categorical exclusion for "gender reassignment surgery," Dr. Toomey's Network Provider—Blue Cross Blue Shield of Arizona—denied preauthorization for Dr. Toomey's hysterectomy on August 10, 2018. (Exhibit G.)

44. In denying preauthorization, Blue Cross Blue Shield of Arizona did not apply its own internal guidelines for determining whether the hysterectomy is a medically necessary treatment for gender dysphoria. The denial was based solely on the Plan's exclusion for "gender reassignment surgery."

45. The denial letter from Blue Cross Blue Shield of Arizona stated:

> [W]e cannot approve this request because the laparoscopic total hysterectomy with removal of tubes and ovaries surgery, for your diagnosis of transsexualism and gender identity disorder is considered a gender reassignment surgery, which is a benefit exclusion. This finding is based on your benefit plan booklet on pages 56 & 57 under the heading of "Exclusions and General Limitations" which states:
>
> 10.1 Exclusions and General Limitations
>
> "In addition to any services and supplies specifically excluded in any other Article of the Plan Description, any services and supplies which are not

[1] Those criteria are: (a) Two referral letters from qualified mental health professionals; (b) Persistent, well documented gender dysphoria; (c) Capacity to make a fully informed decision and to consent for treatment; (d) Age of majority in a given country; (e) If significant medical or mental health concerns are present, they must be well controlled; and (f) Twelve continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

> described as covered are excluded. In addition, the following are specifically excluded Services and Supplies:
>
> • Gender reassignment surgery."
>
> If you choose to get the laparoscopic total hysterectomy with removal of tubes and ovaries surgery, BCBSAZ will not cover the costs of this service.

(Ex. G at 1.)

CLASS ALLEGATIONS

46. Dr. Toomey brings this action on behalf of himself and a class of similarly situated individuals pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure. Through the "gender reassignment surgery" exclusion, Defendants have "acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Rule 23(b)(2).

47. Class certification is appropriate because Dr. Toomey challenges the facial validity of the Plan's "gender reassignment surgery" exclusion, which denies transgender individuals an equal opportunity to demonstrate that their transition-related surgical care is medically necessary. The denial of that equal opportunity is an injury in fact that can be resolved on a class-wide basis.

48. Dr. Toomey seeks a declaratory judgment and injunction requiring Defendants to remove the Plan's categorical exclusion of coverage for "[g]ender reassignment surgery" and evaluate whether transgender individuals' surgical care for gender dysphoria is "medically necessary" in accordance with the Plan's generally applicable standards and procedures.

49. Dr. Toomey proposes two classes based on the claims against each Defendant.

50. With respect to (a) the Title VII claim against the State of Arizona and the Arizona Board of Regents and (b) the equal protection claim against Defendants Ron

Shoopman, Ram Krishna, Bill Ridenour, Larry Penley, Lyndel Manson, Karrin Taylor Robson, Jay Heiler, and Fred DuVal in their official capacities: the proposed class consists of all current and future employees of the Arizona Board of Regents, who are or will be enrolled in the self-funded Plan controlled by the Arizona Department of Administration, and who have or will have medical claims for transition-related surgical care.

51. With respect to the equal protection claim against Defendants Andy Tobin and Paul Shannon in their official capacities: the proposed class consists of all current and future individuals (including Arizona State employees and their dependents) who are or will be enrolled in the self-funded Plan controlled by the Arizona Department of Administration, and who have or will have medical claims for transition-related surgical care.

52. Each of the proposed classes is so numerous that joinder of all members is impracticable.

53. For each of the proposed classes, there are questions of law or fact common to the class. Because Dr. Toomey brings a facial challenge, the class claims do not depend on whether a particular individual's transition-related surgery is ultimately proven to be medically necessary. Dr. Toomey merely seeks declaratory relief and an injunction providing all class members the opportunity to have their claims for transition-related surgery evaluated for medical necessity under the same standards and procedures that the Plan applies to other medical treatments.

54. For each of the proposed classes, the claims or defenses of the representative parties are typical of the claims or defenses of the class.

55. For each of the proposed classes, Dr. Toomey will fairly and adequately protect the interests of the class.

COUNT I
VIOLATION OF TITLE VII
(Against State of Arizona and Arizona Board of Regents)

56. Title VII of the Civil Rights Act of 1964 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)(l).

57. The State of Arizona and the Arizona Board of Regents are employers as that term is defined in Title VII, 42 U.S.C. § 2000e-(a) and (b).

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

59. Discrimination on the basis of transgender status or gender nonconformity is discrimination on the basis of "sex" under Title VII.

60. The employer-sponsored health plan provided by the State of Arizona and the Arizona Board of Regents facially discriminates based on transgender status and gender nonconformity by categorically excluding coverage for all medically necessary "gender reassignment surger[ies]."

61. Because medical transition from one sex to another inherently transgresses gender stereotypes, denying medically necessary coverage based on whether surgery is performed for purposes of "gender reassignment" constitutes impermissible discrimination based on gender nonconformity.

62. Because the need to undergo gender transition is a defining aspect of transgender status, discrimination based on gender transition is discrimination against transgender individuals as a class.

63. By categorically excluding all coverage for "[g]ender reassignment surgery," the Plan deprives Dr. Toomey and other transgender employees of an equal opportunity to

prove that their transition-related surgery is medically necessary under the same standards and procedures that apply to other medical conditions.

64. By providing a facially discriminatory employer-sponsored health plan, the State of Arizona and the Arizona Board of Regents have unlawfully discriminated—and continue to unlawfully discriminate—against Dr. Toomey and members of the proposed class "with respect to [their] compensation, terms, conditions, or privileges of employment, because of . . . sex." 42 U.S.C. § 2000e-2(a)(l).

COUNT II
VIOLATION OF THE EQUAL PROTECTION CLAUSE

(Against Defendants Shoopman, Krishna, Ridenour, Penley, Manson, Robson, Heiler, DuVal, Tobin and Shannon in their official capacities)

65. At all relevant times, Defendants Shoopman, Krishna, Ridenour, Penley, Manson, Robson, Heiler, DuVal, Tobin and Shannon have acted under color of State law.

66. Pursuant to 42 U.S.C. § 1983, Defendants Shoopman, Krishna, Ridenour, Penley, Manson, Robson, Heiler, DuVal, Tobin and Shannon, in their official capacities, are liable for declaratory and injunctive relief for violations of the Equal Protection Clause.

67. In their official capacity as officers and members of the Arizona Board of Regents, Defendants Shoopman, Krishna, Ridenour, Penley, Manson, Robson, Heiler, and DuVal are responsible for the terms and conditions of employment at the University of Arizona.

68. In his official capacity as Director of the Arizona Department of Administration, Defendant Andy Tobin is responsible for "determin[ing] the type, structure, and components of the insurance plans made available by the Department [of Administration]." Ariz. Admin. Code R2-6-103.

69. In his official capacity as Acting Assistant Director of Benefit Services Division of the Arizona Department of Administration, Defendant Paul Shannon has direct oversight and responsibility for administering the benefits insurance programs for State

employees, including employees of the Arizona Board of Regents.

70. The Equal Protection Clause of the Fourteenth Amendment provides: "No State shall . . . deny to any person within its jurisdiction the equal protection of the laws."

71. Arizona State employees are protected by the Equal Protection Clause.

72. The employer-sponsored health plan provided by the State of Arizona and the Arizona Board of Regents facially discriminates based on transgender status and gender nonconformity by categorically excluding coverage for all medically necessary "gender reassignment surgery."

73. Because medical transition from one sex to another inherently transgresses gender stereotypes, denying medically necessary coverage for based on whether surgery is performed for purposes of "gender reassignment" constitutes impermissible discrimination based on gender nonconformity.

74. Because the need to undergo gender transition is a defining aspect of transgender status, discrimination based on gender transition is discrimination against transgender individuals as a class.

75. By categorically excluding all coverage for "[g]ender reassignment surgery," the Plan deprives Dr. Toomey and other transgender employees of an equal opportunity to prove that their transition-related surgical is medically necessary under the same standards and procedures that apply to other medical conditions.

76. By providing a facially discriminatory employer-sponsored health plan, the State of Arizona and the Arizona Board of Regents, by and through Defendants Shoopman, Krishna, Ridenour, Penley, Manson, Robson, Heiler, DuVal, Tobin and Shannon, acting in their respective official capacities, have unlawfully discriminated—and continue to unlawfully discriminate—against Dr. Toomey and members of the proposed class on the basis of gender, which is subject to heightened scrutiny under the Equal Protection Clause.

77. By providing a facially discriminatory employer-sponsored health plan, the

State of Arizona and the Arizona Board of Regents, by and through Defendants Shoopman, Krishna, Ridenour, Penley, Manson, Robson, Heiler, DuVal, Tobin and Shannon, acting in their respective official capacities, have unlawfully discriminated—and continue to unlawfully discriminate—against Dr. Toomey and members of the proposed class on the basis of transgender status, which is independently subject to heightened scrutiny under the Equal Protection Clause.

a. Men and women who are transgender, as a class, have historically been subject to discrimination.

b. Men and women who are transgender, as a class, have a defining characteristic that bears no relation to an ability to perform or contribute to society.

c. Men and women who are transgender, as a class, exhibit immutable or distinguishing characteristics that define them as a discrete group.

d. Men and women who are transgender, as a class, are a minority with relatively little political power.

78. The Plan's discriminatory exclusion is not narrowly tailored to serve a compelling governmental interest.

79. The Plan's discriminatory exclusion is not substantially related to an important governmental interest.

80. The discriminatory exclusion cannot be justified by a governmental interest in limiting coverage to medically necessary treatments because the Plan's general provisions limiting healthcare to "medically necessary" treatments already serves that interest. The only function of the categorical exclusion is to exclude medical care that would otherwise qualify as medically necessary under the Plan's generally applicable standards.

81. The Plan's discriminatory exclusion lacks any rational basis and is grounded

in sex stereotypes, discomfort with gender nonconformity and gender transition, and moral disapproval of people who are transgender.

RELIEF REQUESTED

For the foregoing reasons, Plaintiff respectfully requests that the Court grant the following relief to Dr. Toomey and members of the proposed classes:

A. Declaratory relief, including but not limited to a declaration that Defendants State of Arizona and the Arizona Board of Regents violated Title VII and that Defendants Shoopman, Krishna, Ridenour, Penley, Manson, Robson, Heiler, DuVal, Tobin and Shannon, in their official capacities, violated the Equal Protection Clause;

B. Permanent injunctive relief with respect to all Defendants, requiring Defendants to remove the Plan's categorical exclusion of coverage for "[g]ender reassignment surgery" and evaluate whether Dr. Toomey and the proposed classes' surgical care for gender dysphoria is "medically necessary" in accordance with the Plan's generally applicable standards and procedures.

C. Plaintiffs' reasonable costs and attorneys' fees pursuant to Title VII and 42 U.S.C. § 1988; and

D. Such other relief as the Court deems just and proper.

DATED this 2nd day of March, 2020.

ACLU FOUNDATION OF ARIZONA

By /s/Christine K. Wee
Christine K. Wee

AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Joshua A. Block*
Leslie Cooper*
(*admitted *pro hac vice*)

WILLKIE FARR & GALLAGHER LLP
Wesley R. Powell*
Matthew S. Friemuth*
(**PRO HAC VICE* MOTION TO FOLLOW)

Attorneys for Plaintiff Russell B. Toomey

CERTIFICATE OF SERVICE

I hereby certify that on March 2, 2020, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to all parties.

/s/ Christine K. Wee
Christine K. Wee

EXHIBIT A

ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

BENEFIT OPTIONS

Exclusive Provider Organization (EPO) Summary Plan Description

EFFECTIVE JANUARY 1, 2018

TABLE OF CONTENTS

ARTICLE 1

PLAN MODIFICATION, AMENDMENT AND TERMINATION

The Plan Sponsor reserves the right to, at any time, amend, change or terminate benefits under the Plan; to amend, change or terminate the eligibility of classes of employees to be covered by the Plan; to amend, change, or eliminate any other Plan term or condition; and to terminate the whole Plan or any part of it.

No consent of any Member is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any covered medical expenses incurred prior to the termination date of the Plan.

This Plan document is effective January 1, 2018 and supersedes all Plan Descriptions and all enrollment guides previously issued by the Plan Sponsor.

ARTICLE 2

ESTABLISHMENT OF PLAN

2.1 Purpose

The Plan Sponsor established this Plan to provide for the payment or reimbursement of covered medical expenses incurred by Plan Members.

2.2 Exclusive Benefit

This Plan is established and shall be maintained for the exclusive benefit of eligible Members.

2.3 Compliance

This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. Should any part of this Plan Description, for any reason, be declared invalid, such decision shall not affect the validity of any remaining portion, which remaining portion shall remain in effect as if this Plan Description has been executed with the invalid portion thereof eliminated.

2.4 Legal Enforceability

The Plan Sponsor intends that terms of this Plan, including those relating to coverage and Benefits provided, are legally enforceable by the Members, subject to the Employer's retention of rights to amend or terminate this Plan as provided elsewhere in this Plan Description.

2.5 Note to Members

This Plan Description describes the circumstances when this Plan pays for medical care. All decisions regarding medical care are up to a Member and his Physician. There may be circumstances when a Member and his Physician determine that medical care, which is not covered by this Plan, is appropriate. The Plan Sponsor and the Third Party Claim Administrator do not provide or ensure quality of care.

Each network contracts with the in-network providers under this Plan. These providers are affiliated with the EPO Networks and Travel Network and do not have a contract with the Plan Sponsor or Third Party Claim Administrator.

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility

The Plan is administered in accordance with Section 125 Regulations of the Internal Revenue Code and the Arizona Administrative Code. Benefit Services will provide potential Members reasonable notification of their eligibility to participate in the Plan as well as the terms of participation.

Both Benefit Services and the Third Party Claim Administrator have the right to request information needed to determine an individual's eligibility for participation in the Plan.

Please see Article 17 for definitions of the terms used in this section.

3.2 Member Eligibility

Eligible Employees, Eligible Retirees, and Eligible Former Elected Officials may participate in the Plan.

Members' legal Spouse and eligible children under the age of 26 may participate in the Plan. An Eligible Dependent may not participate in the Plan unless an Eligible Employee, Eligible Retiree, or Eligible Former Elected Official is also enrolled. Please see Article 17 for definitions of the terms used in this section.

If you and your Spouse are both covered under the Plan, you may each be enrolled as a Member or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll their child as a Dependent.

3.3 Continuing Eligibility through COBRA

See Section 3.13 of this article.

3.4 Non-COBRA Continuing Eligibility

The following individuals are eligible for continuing coverage under the Plan.

Eligible Employee on Leave without Pay

An Employee who is on leave without pay for a health-related reason that is not an industrial illness or injury, may continue to participate in the Plan by paying both the state and Employee contribution. Eligibility shall terminate on the earliest of the Employee:

- Receiving long-term disability benefits that include the benefit of continued participation;
- Becoming eligible for Medicare coverage; or

- Completing 30 months of leave without pay.

An Employee who is on leave without pay for other than a health-related reason may continue to participate in the Plan for a maximum of six months by paying both the state and Employee contributions.

Surviving Dependent(s) of Insured Retiree
Upon the death of a Retiree insured under the Plan, the Surviving Dependents are eligible to continue coverage under the Plan, provided each was insured at the time of the Member's death, by payment of the Retiree premium.

If the Spouse survives, he/she, for purposes of Plan administration, will be reclassified as a Member. As such, he/she may enroll Dependents as allowed under Section 3.2. Coverage for the Surviving Spouse may be continued indefinitely.

In the case where children, who are Eligible Dependents of the Surviving Spouse, survive, they may continue participation in the Plan if enrolled by the Surviving Spouse as allowed under Section 3.2.

In the case where children survive but no Spouse survives or the children are Eligible Dependents of the Spouse, each Child, for purposes of Plan administration, will be reclassified as a Member. As such, each Child may enroll Dependents as allowed under Section 3.2. In this circumstance, coverage for each Surviving Child may be continued indefinitely.

Please note that a Dependent not enrolled at the time of the Member's death may not enroll as a Surviving Dependent.

Surviving Spouse/Child of Insured Employee Eligible for Retirement under the Arizona State Retirement System (ASRS)
Upon the death of an insured Employee meeting the criteria for retirement under the ASRS, the Surviving Spouse and Children, provided each was enrolled at the time of the Member's death, are eligible to continue participation in the Plan by payment of the Retiree premium.

If the insured Spouse survives, he/she, for purposes of Plan administration, will be reclassified as a Member. As such, he/she may enroll Dependents as allowed under Section 3.2. Coverage for the Surviving Spouse may be continued indefinitely.

In the case where insured Children, who are Eligible Dependents of the Surviving Spouse, survive, they may continue participation in the Plan if enrolled by the Surviving Spouse as allowed under Section 3.2.

In the case where insured Children survive but no Spouse survives, each Child, for purposes of Plan administration, will be reclassified as a Member. As such, each Child may enroll

Dependents as allowed under Section 3.2. In this circumstance, coverage for each Surviving Child may be continued indefinitely.

Please note that a Child/Spouse not enrolled as a Dependent at the time of the Member's death may not enroll as a Surviving Child/Spouse.

Surviving Spouse of Elected Official or Insured Former Elected Official (EORP)
Upon the death of a Former Elected Official insured under the Plan, the Surviving Spouse may continue participation in the Plan, provided that he/she was enrolled at the time of the Member's death, by payment of the Retiree premium. The Surviving Spouse, for purposes of Plan administration, will be reclassified as a Member. As such, he/she may enroll Dependents as allowed under Section 3.2. Coverage for the Surviving Spouse may be continued indefinitely.

Please note that a Spouse not enrolled at the time of the Former Elected Official's death may not enroll as a Surviving Spouse.

Upon the death of an elected official who would have become eligible for coverage upon completion of his/her term, the Surviving Spouse may continue participation in the Plan, provided that he/she was enrolled at the time of the elected official's death, by payment of the Retiree premium. The Surviving Spouse, for purposes of Plan administration, will be reclassified as a Member. As such, he/she may enroll Dependents as allowed under Section 3.2. Coverage for the Surviving Spouse may be continued indefinitely.

Please note that a Spouse not enrolled at the time of the elected official's death may not enroll as a Surviving Spouse.

Surviving Spouse or Dependent of a Law Enforcement Officer Killed in the Line of Duty
Upon the death of an insured Employee meeting the criteria under A.R.S. § 38-1114, the Surviving Spouse and/or Dependent are eligible to participate in the Plan.

3.5 Eligibility Audit

Benefit Services may audit a Member's documentation to determine whether an enrolled Dependent is eligible according to the Plan requirements. This audit may occur either randomly or in response to uncertainty concerning Dependent eligibility.

Both Benefit Services and the Third Party Claim Administrator have the right to request information needed to determine an individual's eligibility for participation in the Plan.

3.6 Grievances Related to Eligibility

Individuals may file a grievance with the Director of the Benefit Services Division regarding issues related to eligibility. To file a grievance, the individual should submit a letter to the Director that contains the following information:

- Name and contact information of the individual filing the grievance;

- Nature of the grievance;
- Nature of the resolution requested; and
- Supporting Documentation

The Director will provide a written response to a grievance within 60 days.

3.7 Enrollment Procedures and Commencement of Coverage

New enrollments or coverage changes will only be processed in certain circumstances. Those circumstances are described below.

3.8 Initial Enrollment

Once eligible for coverage, potential Members have 31 days to enroll and provide required documentation for themselves and their Dependents in the Plan.

It should be emphasized that coverage begins only after an individual has successfully completed the enrollment process by submitting a completed election form and providing any required documentation within 31 days. Benefits will be effective as referenced on the following table. Documentation may be required.

The table below lists pertinent information related to the initial enrollment process.

Category	Must enroll within 31 days	Enrollment contact	Coverage begins on the[1]
Eligible state Employee	Date of hire	Agency liaison	first day of first pay period after completion of enrollment process
Eligible university Employee	Date of hire	Human Resources Office	first day of first pay period after completion of enrollment process
Eligible participating political subdivision Employee	Date of hire	Human Resources Office	*Please contact the appropriate Human Resources Office*
Eligible Retiree	Date of retirement	Benefit Services	first day of first month after completion of enrollment process[2]
Eligible Former Elected Official	Date of leaving office or retiring	Benefit Services	first day of first month after completion of enrollment process[3]

[1] Under no circumstance will coverage for a Dependent become effective prior to the Member's coverage becoming effective.

[2] For state employees entering retirement and their Dependents, coverage begins the first day of the first pay period following the end of coverage as a state employee. This results in no lapse in coverage.

[3] Eligibility is subject to A.R.S. § 38-802.

3.9 Open Enrollment

Before the start of a new Plan Year, Members are given a certain amount of time during which they may change coverage options. Potential Members may also elect coverage at this time. This period is called Open Enrollment.

In general, Open Enrollment for Eligible Employees, Retirees and Former Elected officials is held in October or November.

At the beginning of each year's Open Enrollment period, enrollment information is made available to those eligible for coverage under the Plan. This information provides details regarding changes in benefits as well as whether a current Member is required to re-elect his/her coverage during Open Enrollment (called a "positive" Open Enrollment).

Elections must be made before the end of Open Enrollment. Those elections – or the current elections, if no changes were made and it was not a positive Open Enrollment – will be in effect during the subsequent Plan Year.

Coverage for all groups begins on the first day of the new Plan Year.

It should be emphasized that coverage options change only after an individual has successfully completed the enrollment process by submitting a completed election form and providing any required documentation within 31 days of the end of Open Enrollment period.

3.10 Qualified Life Event Enrollment

If a qualified life event occurs, Members have 31 days[4] to enroll or change coverage options.

Changes made as a result of a qualified life event must be consistent with the event itself, except in the case of HIPAA Special Enrollment.

It should be emphasized that coverage options change only after an individual has successfully completed the enrollment process by submitting a completed election form and providing any required documentation within 31 days of qualifying event.

State Employees should contact the appropriate agency liaison when they choose to change coverage options as a result of a qualified life event. University and political subdivision Employees should contact the appropriate human resources office. Retirees and Former Elected Officials should contact Benefit Services.

For state Employees, most coverage changes become effective on the first day of the first pay period after completion of the enrollment process. For Retirees and Former Elected Officials, most coverage changes become effective on the first day of the first month after completion of

[4] Pursuant to the Children's Health Insurance Program (CHIP) Reauthorization Act, individuals who lose Medicaid or CHIP coverage due to ineligibility have 60 days to request enrollment.

enrollment. University and political subdivision Employees should contact the appropriate human resources office for information regarding the effective date of coverage changes.

A Surviving Spouse/Dependent must submit a completed election form and provide any required documentation within six months of the death of the insured Retiree or insured Employee eligible for retirement under the ASRS. A Surviving Spouse/Dependent of an Elected Official or Formal Elected Official has 31 days to complete the election form and provide required documentation.

The table below lists pertinent information related to the qualified life event enrollment process. It should be noted that not all qualified life events are listed below.

Type of event	**Must enroll/change coverage within 31 days of:**	**Coverage/change in coverage begins on the[5]:**
Marriage	date of the event	See above
Death of Dependent	date of the event	See above
Divorce, annulment, or legal separation	date of the event	See above
Employment status change (beginning employment, termination, strike, lockout, beginning/ ending FMLA, full-time to part-time)	date of the event	See above
Change in residence	date of the event	See above
Loss/gain of Dependent eligibility (other than listed below)	date of the event	See above
Newborn[6]	date of birth	date of birth[7]
Adopted Child	date of placement for adoption	date of adoption[8]
Child placed under legal guardianship	date Member granted legal guardianship	date Member granted legal guardianship[8]
Child placed in foster care	date of placement in foster care	See above

[5] University and political subdivision employees should contact the appropriate human resources office for information regarding effective date of coverage changes.
[6] Born to Member or Member's legal Spouse.
[7] Coverage ends on 31st day after date of birth if Member does not enroll newborn in the Plan.
[8] A Child adopted, placed under legal guardianship, or placed in foster care covered from date of adoption *only if* Member subsequently enrolls Child in the Plan.

3.11 Change in Cost of Coverage

If the cost of benefits increases or decreases during a Plan Year, Benefit Services may, in accordance with Plan terms, automatically change your elective contribution.

When Benefit Services determines that a change in cost is significant, a Member may either increase his/her contribution or elect less-costly coverage.

3.12 Termination of Coverage

Coverage for all Members/Dependents ends at 11:59 p.m. on the date the Plan is terminated. Termination of coverage prior to that time is described in the table below.

Category	Coverage ends at 11:59 p.m. on the earliest of:
Eligible state/university Employee	• last day of the pay period for/in which the Member: ➢ makes last contribution; ➢ fails to meet the requirements for eligibility; or ➢ becomes an active Member of the armed forces of a foreign country; or • last day Member is eligible for extension of coverage.
Eligible participating political subdivision Employee	*Please contact the appropriate human resources office*
Eligible Retiree[9]/Former Elected Official	• last day of the month for/in which the Member: ➢ makes last premium payment; or ➢ fails to meet the requirements for eligibility.
Eligible long-term disability recipient	• last day of the month in which the disability benefit ends.
Eligible Dependent	• the last day of the month in which the Dependent Child reaches the limiting age of 26; • day the Dependent: ➢ dies; ➢ loses eligibility for reason other than limiting age; or ➢ becomes an active Member of the armed forces of a foreign country; or • day the Member: ➢ is relieved of a court-ordered obligation to furnish coverage for a Dependent Child; or ➢ is no longer covered.

[9] Excluding long-term disability recipient.

Category	Coverage ends at 11:59 p.m. on the earliest of:
Eligible Employee on leave without pay	• last day of period in which Member becomes eligible for: ➢ long-term disability benefits for which there is eligibility to continue coverage under the Plan; or ➢ coverage under Medicare; or • 30 months after the leave-without-pay period began; • Last day of the period for which the Member makes last payment.
Surviving Child/Spouse of Eligible Retiree	• last day of the period for which the Member makes last payment; or • day the Surviving Child fails to be eligible as a Child.
Surviving Spouse of elected official or Eligible Former Elected Official	• last day of the period for which the Member makes last payment.

3.13 Continuing Eligibility through COBRA

Eligibility of Enrolled Members/Dependents

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a Member/Dependent who has had a loss of coverage due to a qualifying event may extend his/her coverage under the Plan for a limited period of time.

To be eligible for COBRA coverage, a Member/Dependent must be covered under the Plan on the day before the qualifying event. Each covered individual may elect COBRA coverage separately. For example, a Dependent Child may continue coverage even if the Member does not.

Members and Dependents would be eligible for COBRA coverage in the event that the State of Arizona files bankruptcy under Title 11 of the U.S. Code.

The table below lists individuals who would be eligible for COBRA coverage if one of the corresponding qualifying events were to occur.

Category	Duration of COBRA coverage	Qualifying event
Eligible Employee, Dependent	Up to 18 months[10]	• Voluntary or involuntary termination of Member's employment for any reason other than "gross misconduct"; or • Reduction in the number of hours worked by Member (including retirement)[11].

[10] If the Member and/or Dependent has a disability when he/she becomes eligible for COBRA or within the first 60 days of COBRA coverage, duration of coverage may be extended to 29 months. See Section 3.16 for Special Rules Regarding Disability.

Category	Duration of COBRA coverage	Qualifying event
Dependent	Up to 36 months	• Member dies; or Member and Dependent Spouse divorce or legally separate
Dependent Child	Up to 36 months	• Dependent Child no longer meets eligibility requirements.

3.14 Subsequent Qualifying Events

An 18-month COBRA period may be extended to 36 months for a Dependent if:

- Member dies; or
- Member and Dependent Spouse divorce or legally separate; or
- Dependent Child no longer meets eligibility requirements.

This clause applies only if the second qualifying event would have caused the Dependent to lose coverage under the Plan had the first qualifying event not occurred.

3.15 Eligibility of Newly Acquired Eligible Dependents

If the Member gains an Eligible Dependent during COBRA coverage, the Dependent may be enrolled in the Plan through COBRA. The Member should provide written notification to Benefit Services within 31 days of the qualifying life event. Newly acquired Dependents may not enroll in the COBRA coverage after 31 days.

3.16 Special Rules Regarding Disability

The 18 months of COBRA coverage may be extended to 29 months if a Member is determined by the Social Security Administration to have a disability at the time of the first qualifying event or during the first 60 days of an 18-month COBRA coverage period. This extension is available to all family Members who elected COBRA coverage after a qualifying event.

To receive this extension, the Member must provide Benefit Services with documentation supporting the disability determination within 60 days after the latest of the:

- Social Security Administration disability determination;
- Qualifying event; or
- Date coverage is/would be lost because of the qualifying event.

3.17 Payment for COBRA Coverage

Participants who extend coverage under the Plan due to a COBRA qualifying event must pay 102% of the active premium. Participants whose coverage is extended from 18 months to 29

[11] If the Member takes a leave of absence qualifying under the Family and Medical Leave Act (FMLA) and does not return to work, the COBRA qualifying event occurs on the date the Member notifies ADOA that he/she will not return, or the last day of the FMLA leave period, whichever is earlier.

months due to disability may be required to pay up to 150% of the active premium beginning with the 19th month of COBRA coverage.

COBRA coverage does not begin until payment is made to the COBRA administrator. A participant has 45 days from submission of his/her application to make the first payment. Failure to comply will result in loss of COBRA eligibility.

3.18 Notification by the Member/Dependent

COBRA coverage cannot be elected if proper notification is not made. Under the law, the Plan must receive written notification of a divorce, legal separation, or Child's loss of Dependent status, within 60 days of the later of the:

- Date of the event; or
- Date coverage would be lost because of the event.

Notification must include information related to the Member and/or Dependent(s) requesting COBRA coverage. Documentation may be required.

Written notification should be directed to:

ADOA Benefit Services Division
100 N. 15th Avenue, Suite 260
Phoenix, AZ 85007

3.19 Notification by the Plan

The Plan is obligated to notify each participant of his/her right to elect COBRA coverage when a qualifying event occurs and the Plan is notified in accordance with Section 3.18.

3.20 Electing COBRA Coverage

Information related to COBRA coverage and enrollment may be obtained through an agency liaison or by calling ADOA Benefit Services Division at 602-542-5008 or 1-800-304-3687 or by writing to the address provided in Article 16.

3.21 Early Termination of COBRA Coverage

The law provides that COBRA coverage may, for the reasons listed below, be terminated prior to the 18-, 29-, or 36-month period:

- The Plan is terminated and/or no longer provides coverage for Eligible Employees;
- The premium is not received within the required timeframe;
- The Member enrolls in another group health plan; or
- The Member becomes eligible for Medicare.

For Members whose coverage was extended to 29 months due to disability, COBRA coverage will terminate after 18 months or when the Social Security Administration determines that the Member no longer has a disability.

3.22 Contact Information for the COBRA Administrator

COBRA-related questions or notifications should be directed to ADOA Benefit Services Division at 602-542-5008 or 1-800-304-3687 or by writing to the address provided in Section 3.18.

3.23 Certificate of Creditable Coverage

When COBRA coverage ends, the medical vendor will send a certificate of creditable coverage. This certificate confirms that each participant was covered under the Plan and for what length of time.

ARTICLE 4

PRE-CERTIFICATION/PRIOR AUTHORIZATION AND NOTIFICATION FOR MEDICAL SERVICES AND PRESCRIPTION MEDICATION

4.1 Pre-Certification/Prior Authorization and Notification

Pre-Certification/Prior Authorization is the process of determining the Medical Necessity of services before the services are incurred. This ensures that any medical care a Member receives meets the Medical Necessity requirements of the Plan. The definition and requirements of Medical Necessity are identified in Article 17. Pre-Certification/Prior Authorization is required if the Plan is considered primary as defined in Article 11. Pre-Certification/Prior Authorization is initiated by calling the toll-free Pre-Certification/Prior Authorization phone number shown on your ID card and providing information on the planned medical services. Pre-Certification/Prior Authorization may be requested by you, your Dependent or your Physician. However, the Member is ultimately responsible to ensure Pre-Certification/Prior Authorization is obtained.

All decisions regarding medical care are up to a Patient and his/her Physician. There may be circumstances when a Patient and his/her Physician determine that medical care, which is not covered by this Plan, is appropriate. The Plan Sponsor and the Third Party Claim Administrator do not provide or ensure quality of care.

Pre-Certification/Prior Authorization should be initiated for specific services noted in the Plan Description by calling the Third Party Claim Administrator Customer Service Center and providing information on the planned medical services. The patient or the physician/facility may request Pre-Certification/Prior Authorization; however, the Member is ultimately responsible to ensure Pre-Certification/Prior Authorization is obtained.

If Pre-Certification/Prior Authorization is not obtained before planned medical services are incurred, the submitted claim will pend and a letter will be issued notifying you and the provider that Pre-Certification/Prior Authorization is required before claim processing can continue. This must be initiated by calling the Third Party Claim Administrator and providing information on the incurred medical services. If Pre-Certification/Prior Authorization is not initiated within 60 days of the first pend letter, the claim will be denied.

4.2 Treatment by Participating Providers

If you do not pre-certify as required above, the Claims Administrator will review the claims submitted for Medical Necessity after the services have been rendered. If the claim is denied based on the Plan provisions or Medical Necessity, the Plan is not responsible for payment.

4.3 Treatment by Non-Participating Providers

Except in emergency situations, treatment provided by a Non-Participating Provider is not covered by the Plan. However, there may be rare circumstances where the Plan will provide coverage for services rendered by a Non-Participating Physician (e.g. there is only one specialist who is able to treat your specific disease and that specialist does not contract with the

network). The only way you can obtain coverage in these instances is by obtaining Pre-Certification/Prior Authorization.

4.4 Medical Services Inpatient Admissions

Pre-Certification/Prior Authorization for inpatient admissions refers to the process used to certify the medical necessity and length of any hospital confinement as a registered bed patient. Pre-Certification/Prior Authorization is performed through a utilization review program by a Third Party Claim Administrator with which the State of Arizona has contracted. Pre-Certification/Prior Authorization should be requested by you, your Dependent or an attending Physician by calling the Pre-Certification/Prior Authorization phone number shown on your ID card prior to each inpatient hospital admission. Pre-Certification/Prior Authorization should be requested, prior to the end of the certified length of stay, for continued inpatient hospital confinement.

You should start the Pre-Certification/Prior Authorization process by calling the Medical Management Organization prior to an elective admission, prior to the last day approved for a current admission, or in the case of an emergency admission, by the end of the second scheduled business day after the admission. The Third Party Claim Administrator will continue to monitor the confinement until you are discharged from the hospital. The results of the review will be communicated to the Member, the attending Physician, and the Third Party Claim Administrator.

The Third Party Claim Administrator is an organization with a staff of Registered Nurses and other trained staff members who perform the Pre-Certification/Prior Authorization process in conjunction with consultant Physicians.

4.5 Other Services and Supplies

Pre-Certification/Prior Authorization should be requested for those services that require Pre-Certification/Prior Authorization. Pre-Certification/Prior Authorization should be requested by you, your Dependent or your Physician by calling the toll-free phone number shown your ID card prior to receiving services. Services that should be pre-certified include, but are not limited to:

1. Inpatient services in a hospital or other facility (such as hospice or skilled nursing facility);
2. Inpatient maternity services in a hospital or birthing center exceeding the federally mandated stay limit of 48 hours for a normal delivery or 96 hours for a cesarean section;
3. A separate Pre-Certification/Prior Authorization is required for a newborn in cases where the infant has been diagnosed with a medical condition requiring in-patient services independent of the maternity stay;
4. Outpatient surgery in a hospital or ambulatory surgery center as required by the Third Party Claim Administrator;
5. Accidental dental services;
6. Dental confinements/anesthesia required due to a hazardous medical condition;
7. Inpatient mental/nervous and substance abuse services;

8. Outpatient and ambulatory magnetic resonance imaging (MRI/MRA), PET Scans, BEAM (Brain Electrical Activity Mapping);
9. Non-emergency ambulance transportation;
10. Organ transplant services;
11. Cancer clinical trials;
12. Epidural and facet injection, radio frequency ablation and biofeedback;
13. Infusion/IV Therapy in an Outpatient setting as required by the Third Party Claim Administrator;
14. Injectable medication in the Physician's office as required by the Third Party Claim Administrator;
15. Home health including parenteral;
16. Outpatient and ambulatory cardiac testing, angiography, sleep testing (including sleep studies and polysomnography), video EEG;
17. All purchase or rental of Durable Medical Equipment and prosthetics as required by the Third Party Claim Administrator;
18. Coverage for repair or replacement equipment;
19. Foot Orthotic devices and inserts (covered only for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.);
20. Repair or replacement of prosthetics;
21. End Stage Renal Disease services (including dialysis);
22. Services not available through an in-network provider;
23. Services which have a potential for a cosmetic component, including but not limited to, blepharoplasty (upper lid), breast reduction, breast reconstruction, ligation (vein stripping), and sclerotherapy;
24. CAT/CT imagery;
25. Injections given during an office visit as required by the Third Party Claim Administrator;
26. Cochlear Implants, and hearing aids;
27. Treatment for Autism Spectrum Disorder;
28. Medical foods, metabolic supplements and Gastric Disorder Formula;
29. Orthognathic treatment or surgery.

4.6 Notification of 23-Hour Observation Admissions

While Pre-Certification/Prior Authorization is not required for 23-hour observation admissions, we encourage you to contact the Third Party Claim Administrator if you will be receiving these services. This will assist in the Pre-Certification/Prior Authorization process should the admission exceed 23 hours.

4.7 Notification of Maternity Services

While Pre-Certification/Prior Authorization is not required for maternity services in the physician's office, outpatient, and inpatient within federally mandated stay limits, we

encourage you to contact the Third Party Claim Administrator if you will be receiving any maternity services. This will assist in the Pre-Certification/Prior Authorization process should inpatient services be required that exceed 48 hours for a normal delivery and 96 hours for a cesarean section. Notification also enables the Third Party Claim Administrator staff to assist you with education and/or resources to maintain your health during your pregnancy.

4.8 Prescription Medications

Medicare Part D participants have dual drug coverage. For drugs covered under Medicare Part D, the following does not apply, please refer to www.medicaregenerationrx.com/stateofaz. For drugs not covered under Medicare Part D the following applies.

For the purposes of Member safety, certain prescriptions require "prior authorization" or approval before they will be covered, including but not limited to an amount/quantity that can be used within a set timeframe, an age limitation has been reached and/or exceeded or appropriate utilization must be determined. The Pharmacy Benefit Management Vendor (PBM), in their capacity as pharmacy benefit manager, administers the prior authorization process for prescription medications.

Prior Authorization (PA) may be initiated by the pharmacy, the physician, you, and/or your covered family Members by calling the PBM. The pharmacy may call after being prompted by a medication denial stating *"Prior Authorization Required."* The pharmacy may also pass the information on to you and require you to follow-up.

After the initial call is placed, the Clinical Services Representative obtains information and verifies that the Plan participates in a PA program for the particular drug category. The Clinical Services Representative generates a drug specific form and faxes it to the prescribing physician. Once the fax form is received by the Clinical Call Center, a pharmacist reviews the information and approves or denies the request based on established protocols. Determinations may take up to 48 hours from the PBM's receipt of the completed form, not including weekends and holidays.

If the PA request is APPROVED, the PBM Clinical Service Representative calls the person who initiated the request and enters an override into the PBM processing system for a limited period of time. The pharmacy will then process your prescription.

If the PA request is DENIED, the PBM Clinical Call Center pharmacist calls the person who initiated the request and sends a denial letter explaining the denial reason. The letter will include instructions for appealing the denial. For more information, see the "Appeals Procedures" section of this document.

The criteria for the PA program are based on nationally recognized guidelines; FDA approved indications and accepted standards of practice. Each specific guideline has been reviewed and approved by the PBM Pharmacy and Therapeutics (P&T) Committee for appropriateness. Types of prescription medications that require PA prior to dispensing include, but are not limited to:

1. Oncology Medications;
2. Multiple Sclerosis Medications;
3. Rheumatoid Arthritis Medications;
4. Lipid Lowering Medications;
5. Testosterone Replacement Medications.

Medication(s) included in medication management programs, including but not limited to, an amount or quantity that can be used within a set timeframe or an age limitation, may be subject to PA. Medication management programs are subject to change and are maintained and updated as medications are FDA approved within the defined therapeutic class and as clinical evidence requires. Medications subjected to quantity limits include, but are not limited to certain medications listed below:

1. Asthma/COPD Agents beyond defined quantity limitations;
2. Oral Antiemetics beyond defined quantity limitations;
3. Medications to treat insomnia beyond defined quantity limitations;
4. Medications used to treat migraine headaches beyond defined quantity limitations.

A certain class of medications will be managed through the PBM's Specialty Pharmacy Program. For more information, on what is covered see the "Specialty Pharmacy" section of this document. Medications that may be included in this program are used to treat chronic or complex health conditions, may be difficult to administer, may have limited availability, and/or may require special storage and handling. A subset of the medications included in the PBM Specialty Pharmacy Program requires prior authorization.

To confirm whether you need a PA and/or to request a PA, you may call the Pharmacy Benefit Management Vendor listed on your ID card or visit the PBM website to review the formulary. Please have the information listed below when initiating your request for PA:

- Name of Medication
- Physician's Name
- Physician's Phone Number
- Physician's Fax Number, if available
- Member ID number (from ID card)
- Rx Group ID number (from ID card)

ARTICLE 5

CASE MANAGEMENT / DISEASE MANAGEMENT AND INDEPENDENT MEDICAL ASSESSMENT

5.1 Case Management

Case Management is a service provided by the Third Party Claim Administrator, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, some trained in a clinical specialty area such as high risk pregnancy or mental health, and others who work as generalists dealing with a wide range of conditions in general medicine and surgery. In addition, Case Managers are supported by physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager may recommend alternate treatment programs and help coordinate needed resources, the patient's attending physician remains responsible for ordering and guiding the actual medical care.

You, your Dependent, or an attending physician may request Case Management services by calling the toll-free phone number shown on your ID card during normal business hours, Monday through Friday. In addition, the Third Party Claim Administrator or a utilization review program may refer an individual for Case Management.

Each case is assessed to determine whether Case Management is appropriate. You or your Dependent will be contacted by an assigned Case Manager who explains in detail how the program works.

Following an initial assessment, the Case Manager works with you, your family and physician to determine the needs of the patient and to identify what alternate treatment programs are available. (For example, in-home medical care in lieu of extended hospital convalescence.) You are not penalized if the alternate treatment program is not followed.

The Case Manager arranges for alternate treatment services and supplies, as needed. (For example, nursing services or a hospital bed and other durable medical equipment for the home.)

The Case Manager also acts as a liaison between the patient, his or her family, and physician as needed. (For example, by helping you to understand a complex medical diagnosis or treatment plan.)

Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

Case Management professionals may offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

5.2 Disease Management

Disease Management is a service provided by the Third Party Claim Administrator, which assists Members with treatment needs for chronic conditions. If you are being treated for certain conditions which have been initiated under this program, you will be contacted by the Disease Management staff with further information on the program. The goal of Disease Management is identification of areas in which the staff may assist you with education and/or resources to maintain your health.

5.3 Independent Medical Assessment

The Plan reserves the right to require independent medical assessments to review appropriateness of treatment and possible alternative treatment options for any Member participating in the Plan. The individual medical assessments may take place on site or via medical record review and will be carried out by a licensed/board certified medical doctor specializing in the area of treatment rendered to the Member. Independent medical assessments may be utilized in instances where current treatment is atypical for the diagnosis, where the current treatment is complex and involves many different providers, and/or the current treatment is of high cost to the Plan. If an independent medical assessment is required, the enrolled person will be notified in writing.

ARTICLE 6

TRANSITION OF CARE

6.1 Transition of Care

If you are a new Member, upon written request to the Third Party Claim Administrator, you may continue an active course of treatment with your current health care provider who is a Non-Participating Provider and receive in-network benefit levels during a transitional period after the effective date of coverage if one of the following applies:

1. You have a life threatening disease or condition;
2. If you have been receiving care and a continued course of covered treatment is Medically Necessary, you may be eligible to receive "transitional care" from the Non-Participating Provider;
3. Entered the third trimester of pregnancy on the effective date of enrollment; or
4. If you are in your second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan's policies and procedures and quality assurance requirements.

There may be additional circumstances where continued care by a provider no longer participating in the network will not be available, such as when the provider loses his license to practice or retires.

Transitions of Care request forms are available by contacting the Third Party Claim Administrator Customer Service Center or by visiting their website.

ARTICLE 7

OPEN ACCESS TO PROVIDERS

Open access refers to how you "access" physicians. This Plan does not require Members to designate a Primary Care Physician (PCP) and Members may schedule an appointment directly with a specialist of his/her choosing; however, the specialist MUST be contracted within your medical plan provider network.

Members may still choose to maintain a primary relationship with one physician and are encouraged to do so, but are not required to. For assistance finding a health care provider, contact the member services office at the number listed on your ID card.

In order for eligible services to be covered by this Plan, it is the Member's responsibility to confirm the facilities, specialists and physicians they use are contracted with his/her medical plan network of providers at the time services are provided.

ARTICLE 8

SCHEDULE OF MEDICAL BENEFITS
COVERED SERVICES AND SUPPLIES

8.1 Schedule of Medical Benefits Covered Services and Supplies Chart

It is important to note that all inpatient services, specific outpatient services, and certain prescription medications require Pre-Certification/Prior Authorization. Please refer to Article 4 of this document for details.

	Out-of-Pocket Maximum per Plan Year	Lifetime Maximum
Employee Only	$7,350	Unlimited
Employee plus Adult	$14,700	
Employee plus Child	$14,700	
Family	$14,700	

PREVENTIVE CARE/WELLNESS SERVICES Refer to Section 8.55 for more information	
Well Child	No Copayment
Well Adult	No Copayment
Immunizations	No Copayment
Preventive Laboratory, Radiology, or Other Tests	No Copayment
OUTPATIENT SERVICES Copayment is subject to one per day per provider	
Physician Visit General Practice, Family Practice, Obstetrics & Gynecology, Internal Medicine, and Pediatrician	$20.00
Specialist Visit	$40.00
Urgent Care	$75.00
Chiropractic & Osteopathic Services	$40.00
Minor Diagnostic and Therapeutic Laboratory and X-Ray Services Refer to Section 8.23 for more information	No Copayment
Major Diagnostic Radiology Services Refer to Section 8.23 for more information	$100.00
Maternity Care Services Includes initial diagnosis, prenatal visits, and delivery	$20.00
Freestanding Ambulatory Facility	$100.00
Outpatient Surgical Facility	$100.00
Therapy Services Refer to Short-term Rehabilitative Therapy Section 8.59	$40.00

Allergy Testing, Treatment, or Injections	$40.00
Immunizations (Non-Preventive) Refer to Section 8.31 for more information	$20.00
INPATIENT SERVICES	
Ambulance Services For medical emergency or required interfacility transport. Non-emergency transportation requires pre-certification.	No Copayment
Hospital Admission Including Intensive Care Unit and private rooms when Medically Necessary. Excludes Subacute Care, Post-Acute Care, Hospice, Bariatric Surgery, and Maternity Admission. Subacute Care includes but is not limited to long-term care, hospital based skilled nursing facilities (SNFs), and free-standing SNFs.	$250.00
Emergency Room Must be a medical emergency as defined by the Plan. Copayment waived if admitted but subject to hospital admission copayment	$200.00
Bariatric Surgery	20% Coinsurance
Hospice Care	No Copayment
Skilled Nursing Facility	No Copayment
Rehabilitation Facility and Subacute Care Facility	No Copayment
MENTAL HEALTH SERVICES	
Physician Visit	$20.00
Specialist Visit	$40.00
Inpatient and Residential	$250.00
OTHER	
Autism Spectrum Disorder Services Refer to Section 8.7 for more information	$20.00 Physician Visit $40.00 Specialist Visit
Durable Medical Equipment Medically Necessary	No Copayment
Hearing Aids Limited to one per ear, per Plan Year, refer to Section 8.28 for more information	No Copayment
Home Health / Home Infusion Care Limited to 42 visits per Plan Year, refer to Section 8.29 for more information	No Copayment
Mammography Screening	No Copayment
Nutritional Evaluation	$20.00
Organ and Tissue Transplant Services	No Copayment
Ostomy Supplies	No Copayment
Prostate Screening	No Copayment

8.2 Determination of Eligible Expenses

Subject to the exclusions, conditions, and limitations stated in this document, the Plan will pay Benefits to, or on behalf of, a Member for covered Medical Expenses described in this section, up to the amounts stated in the Schedule of Benefits.

The Plan will pay Benefits for the Reasonable and Customary Charges or the contracted fee as determined by the Provider's contract with the Network for services and supplies which are ordered by a Physician. Services and supplies must be furnished by an Eligible Provider and be Medically Necessary.

The obligation of the Plan shall be fully satisfied by the payment of allowable expenses in accordance with the Schedule of Benefits. Benefits will be paid for the reimbursement of medical expenses incurred by the Member if all provisions mentioned in this document are satisfied.

All payments made under this Plan for allowable charges will be limited to Reasonable and Customary Charges or the contracted fee as determined by the Provider's contract with the Network minus all copays and coinsurance stated in the Schedule of Benefits.

8.3 Out-of-Pocket Maximum for Participating Provider Expenses

Out-of-Pocket Expenses are a portion of the covered expense for which the participant is financially responsible. All charges associated with a non-covered service and all charges in excess of Reasonable and Customary do not apply toward the accumulation of the out-of-pocket maximum.

For Members under the Employee Only tier:
When a Member enrolled in the EPO Plan has paid the Out-of-Pocket Maximum Expenses of $7,350 in a Plan Year for Participating Provider claims, benefits for Covered Expenses incurred during the rest of the Plan Year will be payable at the rate of 100% of the Reasonable and Customary Charge or the contracted fee as determined by the Provider's contract with the Network.

For Members under the Employee plus Adult, Employee plus Child, and Family Only tiers:
When a single Member enrolled in the EPO Plan has paid $7,350 of the $14,700 Out-of-Pocket Maximum expense in a Plan Year for Participating Provider claims, benefits for Covered Expenses incurred during the rest of the Plan Year will be payable at the rate of 100% of the Reasonable and Customary Charge or the contracted fee as determined by the Provider's contract with the Network for that Member.

When two or more Members enrolled in the EPO Plan have paid a combined amount of the Out-of-Pocket Maximum Expenses of $14,700 in a Plan Year for Participating Provider claims, benefits for Covered Expenses for the Employee and all Eligible Dependents incurred during the rest of the Plan Year will be payable at the rate of 100% of the Reasonable and Customary Charge or the contracted fee as determined by the Provider's contract with the Network.

8.4 Notification, Proof of a Claim, and Payment

Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and Pre-Certification/Prior Authorization by the Third Party Claim Administrator.

Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than the second business day after admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to the Third Party Claim Administrator as soon as reasonably possible.

Coverage for Emergency Services received through Non-Participating Providers at an Inpatient or Emergency Room Facilities shall be limited to covered services to which you would have been entitled under the Plan, and shall be reimbursed at billed charges in cases where no discounts are achieved through the Third Party Claims Administrator.

Claims and supporting documentation submitted for reimbursement must meet the Timely Filing requirements and be received within one (1) year from the date the services were rendered. Claim forms are available on the Third Party Claim Administrator website or by calling the Customer Service Center.

Foreign Claims: Request for reimbursement of foreign claims must include the following information: Employee name, Member identification number, patient name, date of service, provider name and address, detailed description of the services rendered, charges, and the currency in which the charges are being reported. Foreign travel guidelines are available on the Third Party Claim Administrator website.

8.5 Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person, if they are incurred after he becomes insured for these benefits and prior to the date coverage ends. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of a non-occupational injury or a sickness and outlined below.

The Covered Expenses available to a Member under this Plan are described below. Any applicable copayments and other limits are identified in the Schedule of Benefits. Unless otherwise authorized in writing by the Plan, Covered Expenses are available to Member/Participants only if:

1. They are Medically Necessary and not specifically excluded in this Article or any other Article; and
2. Pre-Certification/Prior Authorization is obtained from the Plan by the Member or provider, for those services that require Pre-Certification/Prior Authorization. To obtain Pre-Certification/Prior Authorization call the number on your ID card.

All non-emergency services within the network Service Area must be incurred at a Participating Provider. All non-emergency services outside of the network Service Area must be incurred at a Travel Network Participating Provider.

If a Member uses Participating Providers for facility and physician services for a given procedure, any assistant surgeon, anesthesiologist, radiologist, and pathologist charges in connection with that procedure will be payable at the in-network level of benefits even if rendered by Non-Participating Providers. During an inpatient admission, if a consultation is required by a specialist on call at the facility causing the Member to have no control over the provider chosen, charges in connection with the consult will be payable at the in-network level of benefits even if rendered by Non-Participating Providers. Covered charges will be reimbursed at in-network benefit levels subject to Reasonable and Customary rates.

8.6 Copayment

The Copayment (Copay) amount noted in the Schedule of Benefits is the amount you are responsible for paying each time you receive certain covered health services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. If the total eligible expenses are less than the Copay, you are responsible for paying the eligible expenses.

8.7 Autism Spectrum Disorder Services

Behavioral therapy is only covered for the treatment of Autism Spectrum Disorder as defined in Article 17.

Short-term rehabilitative therapy included in an outpatient facility or physician's office that is part of a rehabilitation program for treatment of Autism Spectrum Disorder, including physical, speech, and occupational therapy is subject to the 60 visit benefit limitations described under Section 8.59 Short-Term Rehabilitative Therapy.

The following services are excluded: Sensory Integration, LOVAAS Therapy and Music Therapy.

If multiple services are provided on the same day by different Providers, a separate copayment will apply to each Provider.

8.8 Physician Services

Physician Services are diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, virtual visits, periodic health assessments, well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures.

8.9 Inpatient Hospital Services

Inpatient hospital services are services provided for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in another Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in

an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; admit kit; and other services which are customarily provided in acute care hospitals. Inpatient hospital services also include Birthing Centers.

Private rooms are only provided if deemed medically necessary by the Third Party Claim Administrator. The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice or when a Semi-private Room is not available.

8.10 Outpatient Facility Services

Outpatient facility services are services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

8.11 Emergency Services and Urgent Care

In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your Physician for Emergency Services, but you should call your Physician as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, contact the Third Party Claim Administrator to obtain necessary authorizations for care or hospitalization.

If you receive Emergency Services outside the Service Area, you must notify the Third Party Claim Administrator as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

"Emergency Services" are defined as a medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones. The symptoms that led you to believe you needed emergency care, as

coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for at least a screening examination to determine whether an emergency exists. Care up and through stabilization for an emergency situation is covered without prior authorization.

For Urgent Care services, you should take all reasonable steps to contact your Physician for direction and you must receive care from a Participating Provider, unless otherwise authorized by the Plan. If you are traveling outside of the network's Service Area in which you are enrolled, you should, whenever possible, contact the Plan or your Physician for direction and authorization prior to receiving services.

"Urgent Care" is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by the Plan in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

8.12 Continuing or Follow-up Treatment

Continuing or follow-up treatment by providers out of the Service Area is not covered unless it is Pre-Certified by the Third Party Claim Administrator.

8.13 Ambulance Service

Ambulance services to/from an appropriate provider or facility are covered for emergencies. Pre-Certification/Prior Authorization for non-emergency ambulance services may be obtained from the Third Party Claim Administrator by a provider that is treating the Member.

Covered Expenses include charges for licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided.

8.14 Bariatric Surgery

The Plan covers the following bariatric surgery procedures: open roux-en-y gastric bypass (RYGBP), laparoscopic roux-en-y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), open biliopancreatic diversion with duodenal switch (BPD/DS), laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS), and laparoscopic sleeve gastrectomy (LSG) if all the following criteria are met:

1. The patient must have a body-mass index (BMI) ≥35.
2. Have at least one co-morbidity related to obesity.

3. Previously unsuccessful with medical treatment for obesity. The following medical information must be documented in the patient's medical record:

   Active participation within the last two years in one physician–supervised weight-management program for a minimum of six months without significant gaps. The weight-management program must include monthly documentation of all of the following components:

   a. Weight
   b. Current dietary program
   c. Physical activity (e.g., exercise program)

4. In addition, the procedure must be performed at an approved Center of Excellence facility that is credentialed by your Health Network to perform bariatric surgery.
5. The Member must be 18 years or older, or have reached full expected skeletal growth.

If treatment was directly paid or covered by another plan, medically necessary adjustments will be covered.

The following bariatric procedures are excluded:

1. Open vertical banded gastroplasty;
2. Laparoscopic vertical banded gastroplasty;
3. Open sleeve gastrectomy;
4. Open adjustable gastric banding.

8.15 Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following services and supplies are covered:

1. Surgical services for reconstruction of the breast on which the mastectomy was performed;
2. Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
3. Post-operative breast prostheses; and
4. Mastectomy bras/camisoles and external prosthetics that meet external prosthetic placement needs.

During all stages of mastectomy, treatments of physical complications, including lymphedema, are covered.

8.16 Cancer Clinical Trials

Coverage shall be provided for Medically Necessary covered patient costs that are directly associated with a cancer clinical trial that is offered in the State of Arizona and in which the

Member participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; and (f) methods for documenting and treating adverse reactions;
2. The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial;
3. The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the National Institutes of Health; (b) A National Institutes of Health Cooperative Group or Center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; (f) a qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility; or (g) a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona;
4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in the State of Arizona;
5. The personnel providing the treatment or conducting the study (a) are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise; (b) agree to accept reimbursement as payment in full from the Plan at the rates that are established by the Plan and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers with the Plan's network;
6. There is no clearly superior, non-investigational treatment alternative;
7. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

For the purposes of this specific covered service and benefit, coverage outside the State of Arizona will be provided under the following conditions:

(a) The clinical trial treatment is curative in nature; (b) The treatment is not available through a clinical trial in the State of Arizona; (c) There is no other non-investigational treatment alternative;

For the purposes of this specific covered service and benefit, the following definitions apply:

1. "Cooperative Group" – means a formal network of facilities that collaborates on research projects and that has an established national institute of health approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and The National Cancer Institute Community Clinical Oncology Program.
2. "Institutional Review Board" – means any board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and (b) approved by the National Institutes of Health Office for Protection From Research Risks.
3. "Multiple Project Assurance Contract" – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.
4. "Patient Cost" – means any fee or expense that is covered under the Plan and that is for a service or treatment that would be required if the patient were receiving reasonable and customary care.

   Patient cost does not include the cost: (a) of any drug or device provided in a phase I cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Plan; and (f) of treatment or services provided outside the State of Arizona.

8.17 Chiropractic Care Services

Chiropractic care services include diagnostic and treatment services utilized in an office setting by Participating Chiropractic Physicians and Osteopaths. Chiropractic treatment includes the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

The following are specifically excluded from chiropractic care and osteopathic services:

1. Services of a chiropractor or osteopath which are not within his scope of practice, as defined by state law;
2. Charges for care not provided in an office setting;
3. Maintenance or preventive treatment consisting of routine, long term or Non-Medically Necessary care provided to prevent reoccurrences or to maintain the patient's current status; and
4. Vitamin therapy.

Services are limited to twenty (20) visits per Member per Plan Year.

8.18 Cosmetic Surgery

Cosmetic Surgery is covered for reconstructive surgery that constitutes necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury. Congenital defects and birth abnormalities are covered for Eligible Dependent Children.

8.19 Compression Garments

Compression garments for treatment of lymphedema and burns are limited to one set upon diagnosis. Coverage of up to four (4) replacements per Plan Year. When determined to be medically necessary by the Third Party Claim Administrator and the compression stocking cannot be repaired or when required due to a change in the Member's physical condition.

8.20 Dental Confinements/Anesthesia

Facility and anesthesia services for hospitalization in connection with dental or oral surgery will be covered, provided that the confinement has been Pre-Certified because of a hazardous medical condition. Such conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia). All facility services must be provided by a contracted network provider.

8.21 Dental Services – Accident Only

Dental services are covered for the treatment of a fractured jaw or an injury to sound natural teeth. Benefits are payable for the services of a Physician, dentist, or dental surgeon, provided the services are rendered for treatment of an accidental injury to sound natural teeth where the continuous course of treatment is started within six (6) months of the accident.

Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch.

8.22 Diabetic Service and Supplies

Coverage will be provided for the following Medically Necessary supplies, devices, and appliances prescribed by a health care provider for the treatment of diabetes:

1. Podiatric appliances for prevention of complications associated with diabetes; foot orthotic devices and inserts (therapeutic shoes: including Depth shoes or Custom Molded shoes.) Custom molded shoes will only be covered when the Member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and *any* of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. Definitions of Depth Shoes and Custom-Molded Shoes are as follows:
   - Depth Shoes shall mean the shoe has a full length, heel-to-toe filler that, when removed, provides a minimum of 3/16th inch of additional depth used to accommodate custom-molded or customized inserts; are made of leather or

other suitable material of equal quality; have some sort of shoe closure; and are available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard sizing schedule or its equivalent.

- Custom-Molded Shoes shall mean constructed over a positive model of the Member's foot; made from leather or other suitable material of equal quality; have removable inserts that can be altered or replaced as the Member's condition warrants; and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

2. Any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management; and
3. Disease Self-Management Training from a Participating Provider is covered when it has a therapeutic role in the care of diabetes.

8.23 Diagnostic and Therapeutic Services

The following outlines the benefits for outpatient major diagnostics, minor diagnostics, therapeutic treatments and scopic procedures:

The following are examples of major diagnostic services:

- Computed tomography (CT) scans
- Positron emission tomography (PET) scans
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Combination CT/PET Scans
- Nuclear medicine
- Any other diagnostic services that would be classified as a major diagnostic service as determined by the Third Party Claims Administrator.

The following are examples of minor diagnostic procedures:

- Laboratory services
- X-ray
- Ultrasounds
- Mammography

The following are examples of therapeutic procedures:

- Radiation therapy
- Chemotherapy
- Dialysis
- IV infusion therapy

Coverage is provided for diagnostic and therapeutic scopic procedures. This includes but is not limited to colonoscopy, sigmoidoscopy and upper gastrointestinal endoscopy.

Diagnostic and therapeutic scopic procedures are those scopic procedures that are done for visualization, biopsy and polyp removal. Those scopic procedures that are surgical would be covered under the Outpatient Surgical benefit.

Scopic procedures when performed in a physician office are covered under the Physician Services benefit. When performed outpatient in a hospital or alternate facility the Outpatient Surgical benefit applies.

8.24 Durable Medical Equipment

Purchase or rental of durable medical equipment and prosthetics is covered when ordered or prescribed by a Participating Physician and provided by a contracted in-network vendor. The determination to either purchase or rent equipment will be made by the Third Party Claim Administrator. Repair or replacement is covered when approved as medically necessary by the Third Party Claim Administrator.

Durable medical equipment is defined as:

1. Generally for the medical or surgical treatment of an Illness or Injury, as certified in writing by the attending medical provider;
2. Serves a therapeutic purpose with respect to a particular Illness or Injury under treatment in accordance with accepted medical practice;
3. Items which are designed for and able to withstand repeated use by more than one person;
4. Is of a truly durable nature;
5. Appropriate for use in the home; and
6. Is not useful in the absence of Illness or Injury.

Such equipment includes, but is not limited to, breast pumps, crutches, hospital beds, wheel chairs, respirators, and dialysis machines.

Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions, the following are specifically excluded:

1. Hygienic or self-help items or equipment;
2. Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
3. Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
4. Institutional equipment, such as air fluidized beds and diathermy machines;
5. Elastic stockings and wigs (except where indicated for coverage);
6. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints;

7. Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
8. Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and
9. Hearing aid batteries (except those for cochlear implants) and chargers.

8.25 External Prosthetic Appliances

The Plan covers the initial purchase and fitting of external prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury, congenital defect, or alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns.

External prosthetic appliances shall include artificial arms and legs, wigs, hair pieces and terminal devices such as a hand or hook. Wigs and hair pieces are limited to one per Plan Year. Members must provide a valid prescription verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, second or third degree burns with a submitted claim for coverage. All other diagnosis are excluded.

Replacement of artificial arms and legs and terminal devices are covered only if necessitated by normal anatomical growth or as a result of wear and tear.

The following are specifically excluded:

1. Myoelectric prosthetic operated through or in conduction with nerve conduction or other electrical impulses.
2. Replacement of external prosthetic appliances due to loss or theft; and
3. Wigs or hairpieces (except where indicated for coverage above).

8.26 Family Planning Services (Contraception and Voluntary Sterilization)

Covered family planning services including:

1. Medical history;
2. Physical examination;
3. Related laboratory tests;
4. Medical supervision in accordance with generally accepted medical practice;
5. Information and counseling on contraception;
6. Implanted/injected contraceptives; and
7. After appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

8.27 Foot Orthotics

Foot Orthotic devices and inserts (covered only for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or

previous amputation of the foot or part of the foot; or poor circulation.); see Section 8.22 Diabetic Services and Supplies:

Custom-molded shoes constructed over a positive model of the Member's foot made from leather or other suitable material of equal quality containing removable inserts that can be altered or replaced as the Member's condition warrants and have some sort of shoe closure. This includes a shoe with or without an internally seamless toe.

8.28 Hearing Aids

Hearing aid devices limited to one per ear, per Plan Year when determined to be medically necessary by the Third Party Claim Administrator. The following services are covered:

- New or replacement hearing aids no longer under warranty (Pre-Certification/Prior Authorization required);
- Cleaning or repair;
- Batteries for cochlear implants.

8.29 Home Health Services

Home health services limited to a maximum of 42 visits per Member per Plan Year are covered when the following criteria are met:

1. The physician must have determined a medical need for home health care and developed a plan of care that is reviewed at thirty day intervals by the physician.
2. The care described in the plan of care must be for intermittent skilled nursing, therapy, or speech services.
3. The patient must be homebound unless services are determined to be medically necessary by the Third Party Claim Administrator.
4. The home health agency delivering care must be certified within the state the care is received.
5. The care that is being provided is not custodial care.

A Home Health visit is considered to be up to four hours of services. Home health services do not include services of a person who is a Member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. Physical, occupational, and speech therapy provided in the home are also subject to the 60 visit benefit limitations described under Section 8.59 Short-Term Rehabilitative Therapy.

8.30 Hospice Services

The Plan covers hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a Participating Provider as having a terminal illness with a prognosis of six (6) months or less to live. Hospice care services include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and home health services.

Hospice care services do not include the following:

1. Services of a person who is a Member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
2. Services and supplies for curative or life prolonging procedures;
3. Services and supplies for which any other benefits are payable under the Plan;
4. Services and supplies that are primarily to aid you or your Dependent in daily living;
5. Services and supplies for respite (custodial) care; and
6. Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by a Participating Hospital; a Participating skilled nursing facility or a similar institution; a Participating home health care agency; a Participating hospice facility, or any other licensed facility or agency under a Medicare approved hospice care program.

A hospice care program is a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and a program for persons who have a terminal illness and for the families of those persons.

A hospice facility is a Participating institution or portion of a facility which primarily provides care for terminally ill patients; is a Medicare approved hospice care facility; meets standards established by the Plan; and fulfills all licensing requirements of the state or locality in which it operates.

8.31 Immunizations

Immunizations are not subject to the annual routine visit limitation. Covered immunizations will be administered according to guidelines and recommendations from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

8.32 Infertility Services

Diagnostic services rendered for infertility evaluation are covered. Any medical treatment and/or prescription related to infertility once diagnosed are excluded by the Plan.

8.33 Inpatient Services at Other Participating Health Care Facilities

Inpatient services include semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids.

Private rooms are only provided if deemed medically necessary by the Third Party Claim Administrator. The Plan will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

8.34 Insulin Pumps and Supplies

Insulin pumps and insulin pump supplies are covered when ordered by a Physician and obtained through a contracted durable medical equipment supplier. You may call the Customer Service number on your ID card if you need assistance locating a contracted supplier.

8.35 Internal Prosthetic/Medical Appliances

Internal prosthetic/medical appliances are prosthetics and appliances that are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following Medically Necessary surgical removal of the testicles. Medically Necessary repair, maintenance or replacement of a covered appliance is covered.

8.36 Mammograms

Mammograms are covered for routine and diagnostic breast cancer screening as follows:

1. A single baseline mammogram if you are age 35-39;
2. Once per Plan Year if you are age 40 and older.

Non-routine services covered more frequently based on recommendation of the Member's Physician if determined to be Medically Necessary by the Third Party Claim Administrator.

8.37 Maternity Care Services

Maternity care services include medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, cesarean section, spontaneous abortion (miscarriage), complications of pregnancy, and maternal risk.

Coverage for a mother and her newly born child shall be available for a minimum of forty-eight (48) hours of inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

These maternity care benefits also apply to the natural mother of a newborn child legally adopted by you in accordance with the Plan adoption policies.

These benefits do not apply to the newly born child of an Eligible Dependent daughter unless placement with the Employee is confirmed through a court order or legal guardianship.

Charges incurred at the birth for the delivery of a child only to the extent that they exceed the birth mother's coverage, if any, provided:

1. That child is legally adopted by you within one year from date of birth;
2. You are legally obligated to pay the cost of the birth;
3. You notify the Plan of the adoption within 60 days after approval of the adoption or a change in the insurance policies, plans or company; and

4. You choose to file a claim for such expenses subject to all other terms of these medical benefits.

8.38 Medical Foods / Metabolic Supplements and Gastric Disorder Formula

Medical foods, metabolic supplements and gastric disorder formula to treat inherited metabolic disorders or a permanent disease/non-functioning condition in which a Member is unable to sustain weight and strength commensurate with the Member's overall health status are covered.

Inherited metabolic disorders triggering medical food coverage are:

1. Part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism;
2. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and
3. Require specifically processed or treated medical foods that are generally available only under the supervision and direction of a physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

For non-inherited disorders, enteral nutrition is considered Medically Necessary when the Member has:

1. A permanent non-function or disease of the structures that normally permit food to reach the small bowel; or
2. A disease of the small bowel which impairs digestion and absorption of an oral diet consisting of solid or semi-solid foods.

For the purpose of this section, the following definitions apply:

"Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute. Medical Foods means modified low protein foods and metabolic formula.

"Metabolic Formula" means foods that are all of the following:

1. Formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy;
2. Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs;
3. Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and
4. Essential to a person's optimal growth, health and metabolic homeostasis.

"Modified Low Protein Foods" means foods that are all of the following:

1. Formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy.
2. Processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein;
3. Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and
4. Essential to a person's optimal growth, health and metabolic homeostasis.

For eosinophilic gastrointestinal disorder, amino acid-based formulas are considered Medically Necessary when:

1. The Member has been diagnosed with eosinophilic gastrointestinal disorder.
2. The Member is under the continuous supervision of a licensed physician.
3. There is a risk of a mental or physical impairment without the use of the formula.

The following are not considered Medically Necessary and are not covered as a metabolic food/metabolic supplement and gastric disorder formula:

1. Standard oral infant formula;
2. Food thickeners, baby food, or other regular grocery products;
3. Nutrition for a diagnosis of anorexia; and
4. Nutrition for nausea associated with mood disorder, end-stage disease, etc.

8.39 Medical Supplies

Medical supplies include Medically Necessary supplies which may be considered disposable, however, are required for a Member in a course of treatment for a specific medical condition. Supplies must be obtained from a Participating Provider. Over the counter supplies, such as band-aids and gauze are not covered.

8.40 Mental Health and Substance Abuse Services

Mental Health Services are those services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any conditions of physiological instability requiring medical hospitalization will not be considered to be charges made for treatment of substance abuse.

The Third Party Claim Administrator will review level of care guidelines and determine whether Mental Health and Substance Abuse services will be provided in an inpatient or outpatient setting, based on the Medical Necessity of each situation.

8.41 Inpatient Mental Health Services

Inpatient Mental Health Services are services that are provided by a Participating Hospital for the treatment and evaluation of mental health during an inpatient admission.

8.42 Outpatient Mental Health Services

Outpatient Mental Health Services are services by Participating Providers who are qualified to treat mental health when treatment is provided on an outpatient basis in an individual, group or structured group therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; neuropsychological testing; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention), outpatient testing/assessment, and medication management when provided in conjunction with a consultation.

8.43 Outpatient Substance Abuse Rehabilitation Services

Outpatient substance abuse services include services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program. Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient structured therapy programs provide nine or more hours of individual, family and/or group therapy in a week.

8.44 Mental Health and Substance Abuse Residential Treatment

Voluntary and court-ordered residential substance abuse for mental health and substance abuse treatment are covered.

8.45 Substance Abuse Detoxification Services

Substance abuse detoxification services include detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation. The Third Party Claim Administrator will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

8.46 Excluded Mental Health and Substance Abuse Services

The following are specifically excluded from mental health and substance abuse services:

1. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this Plan;
2. Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
3. Treatment of Chronic Conditions not subject to favorable modification according to generally accepted standards of medical practice;
4. Developmental disorders, including but not limited to:
   a. developmental reading disorders;
   b. developmental arithmetic disorders;
   c. developmental language disorders; or
   d. articulation disorders.
5. Counseling for activities of an educational nature;
6. Counseling for borderline intellectual functioning;
7. Counseling for occupational problems;
8. Counseling related to consciousness raising;
9. Vocational or religious counseling;
10. I.Q. testing;
11. Marriage counseling;
12. Custodial care, including but not limited to geriatric day care;
13. Psychological testing on children requested by or for a school system;
14. Occupational/recreational therapy programs even if combined with supportive therapy forage-related cognitive decline; and
15. Biofeedback is not covered for reasons other than pain management.

8.47 Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

All other services for the purpose of diet control and weight reduction are not covered unless required by a specifically identified condition of disease etiology. Services not covered include but not limited to: gastric surgery, intra oral wiring, gastric balloons, dietary formulae, hypnosis, cosmetics, and health and beauty aids.

8.48 Self-Management Training

Chronic Disease Self-Management Training from a Participating Provider is covered when it has a therapeutic role in the care of a diagnosed chronic disease/condition, including but not limited to:

1. Morbid obesity
2. Diabetes
3. Cardiovascular disease
4. Hypertension
5. Kidney disease
6. Eating disorders
7. Gastrointestinal disorders
8. Food allergies
9. Hyperlipidemia

8.49 Obstetrical and Gynecological Services

Obstetrical and gynecological services are covered when provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions.

8.50 Organ Transplant Services

Human organ and tissue transplant services are covered at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations. Due to the specialized medical care required for transplants, the Provider Network for this specific service may not be the same as the medical network in which you enrolled.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is an organ donor for a recipient other than a Member enrolled on the same family policy.

Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform human to human organ or tissue transplants, such as:

1. Allogeneic bone marrow/stem cell;
2. Autologous bone marrow/stem cell;
3. Cornea;
4. Heart;
5. Heart/lung;
6. Kidney;
7. Kidney/pancreas;
8. Liver;
9. Lung;
10. Pancreas;

11. Small bowel/liver; or
12. Kidney/liver.

Organ transplant coverage will apply only to non-experimental transplants for the specific diagnosis. All organ transplant services other than cornea, kidney and autologous bone marrow/stem cell transplants must be received at a qualified organ transplant facility.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

8.51 Organ Transplant Travel Services

Travel expenses incurred by the Member in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Travel expenses are limited to $10,000. Organ transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available only for the recipient of a pre-approved organ/tissue transplant from a transplant facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following:

1. Evaluation,
2. Candidacy,
3. Transplant event, or
4. Post-transplant care.

All claims filed for travel expenses must include detailed receipts, except for mileage. Transportation mileage will be calculated by the Third Party Claim Administrator based on the home address of the Member and the transplant site. Travel expenses for the Member receiving the transplant will include charges for:

1. Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
2. Transportation to and from the transplant site in a personal vehicle will be reimbursed at the standard IRS medical rate when the transplant site is more than 60 miles one way from the Member's home.
3. Lodging while at, or traveling to and from the transplant site;
4. Food while at, or traveling to and from the transplant site.

In addition to the Member being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany the Member. The term companion includes your Spouse, a Member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

Transplant Travel guidelines can be obtained by contacting your Third Party Claim Administrator.

8.52 Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are covered if approved as medically necessary by the Third Party Claim Administrator.

8.53 Ostomy Supplies

Ostomy supplies are supplies which are Medically Necessary for care and cleaning of a temporary or permanent ostomy. Covered supplies include, but are not limited to pouches, face plates and belts, irrigation sleeves, bags and catheters, skin barriers, gauze, adhesive, adhesive remover, deodorant, pouch covers, and other supplies as appropriate.

8.54 Oxygen and the Oxygen Delivery System

Coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

8.55 Preventive Care Services

Preventive care services are provided on an outpatient basis at a Physician's office, an alternate facility or a hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care benefits defined under the Health Resources and Services Administration requirement include the cost of renting one breast pump per pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, benefits are available only for the most cost effective pump. The Third Party Claim Administrator will determine the following:

1. Which pump is the most cost effective;
2. Whether the pump should be purchased or rented;
3. Duration of a rental;
4. Timing of an acquisition.

Benefits are only available if breast pumps are obtained from an in-network DME provider or Physician.

Preventive care benefits have no copayment only when delivered by a doctor or other provider in the in-network. For questions about preventive care benefits under this Plan contact the Third Party Claim Administrator.

8.56 Prostate Screening

Prostate specific antigen (PSA) screening and digital rectal examination (DRE) are covered annually if the following criteria is met:

1. If you are under 40 years of age and are at high risk because of any of the following:
   a. Family history (i.e., multiple first-degree relatives diagnosed at an early age)
   b. African-American race
   c. Previous borderline PSA levels
2. If you are age 40 and older.

8.57 Routine Physical

Periodic routine health examinations for Members age 4 and over by a physician are limited to one (1) visit per Member per Plan Year.

8.58 Radiation Therapy

Radiation therapy and other therapeutic radiological procedures are covered.

8.59 Short-Term Rehabilitative Therapy

Short-term rehabilitative therapy includes services in an outpatient facility or physician's office that is part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy. Covered expenses are limited to sixty (60) visits per Member per Plan Year, if deemed medically necessary by the Third Party Claim Administrator.

The following limitations apply to short-term rehabilitative therapy except as required for the treatment for Autism Spectrum Disorder:

1. Occupational therapy is provided only for purposes of training Members to perform the activities of daily living.
2. Speech therapy is not covered when:
   a. Used to improve speech skills that have not fully developed;
   b. Considered custodial or educational;

c. Intended to maintain speech communication; or
d. Not restorative in nature.

3. Phase 3 cardiac rehabilitation is not covered.

If multiple services are provided on the same day by different Providers, a separate copayment will apply to each Provider.

8.60 Surgical Procedures – Multiple/Bilateral

Multiple or Bilateral Surgical Procedures performed by one or more qualified physicians during the same operative session will be covered according to the following guidelines:

1. The lesser of the actual charges, Reasonable and Customary amount, or the contracted fee as determined by the Provider's contract with the Network will be allowed for the primary Surgical Procedure.
2. 50% of the lesser of the actual charges, Reasonable and Customary amount, or the contracted fee as determined by the Provider's contract with the Network (not to exceed the actual charge) will be allowed for the secondary Surgical Procedure.

8.61 Temporomandibular Joint (TMJ) Disorder

Benefits are payable for covered services and supplies which are necessary to treat TMJ disorder which is a result of:

1. An accident;
2. Trauma;
3. A congenital defect;
4. A developmental defect; or
5. A pathology.

Covered expenses include diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate treatment for TMJ, including intra-oral splints that stabilize the jaw joint.

8.62 Well Child Health Examinations

Well Child visits and immunizations are covered through 47 months as recommended by the American Academy of Pediatrics.

8.63 Well Adult Examinations

Well adult exams are covered in addition to periodic health exams. Limited to 1 visit per Member per Plan Year.

ARTICLE 9

PRESCRIPTION DRUG BENEFITS

Additional coverage of some prescription drugs not normally covered in a Medicare Part D prescription drug plan may be included in this Plan (enhanced drug coverage). To find out which drugs the Plan covers and any limitations, refer to the formulary. The amount a Member pays when filling a prescription for these drugs does not count towards the total drug costs qualifying for the Medicare Catastrophic Coverage Stage. In addition, if a Member is receiving Extra Help to pay for prescriptions, the Member will not get any Extra Help to pay for these drugs. See the Medicare GenerationRx (Employer PDP) Evidence of Coverage booklet and formulary for more details. These documents are available at www.medicaregenerationrx.com/stateofaz.

9.1 Prescription Drug Benefit

If a Member incurs expenses for charges made by a Pharmacy for Covered Prescription Drugs, the Plan will pay a portion of the expense remaining after you have paid the required Copayment shown in the Schedule of Benefits. The Prescription Drug Benefits are provided through the Plan Sponsor and administered by the Pharmacy Benefit Management vendor, an organization which has been contracted by the Plan Sponsor to perform these services.

Prescription Medication and Diabetic Supplies	Copayment
Diabetic Supplies includes insulin, lancets, insulin syringes/needles, pre-filled cartridges, urine test strips, blood glucose testing machines, blood sugar test strips, and alcohol swabs.	Available through Mail Order and Retail Pharmacy at the copayment outlined below.
Smoking cessation aids both prescribed and over-the counter will be covered. Member must have a prescription and present to an in-network pharmacy for the aid to be covered. Only FDA approved aids will be covered.	No charge
Prescribed preventive medication including certain aspirin, contraceptives, vitamins and other agents as recommended by the USPSTF and the CDC.	No charge
Retail Pharmacy (up to a 30-day supply) Generic Preferred Brand Non-Preferred Brand	 $15.00 $40.00 $60.00
Mail Order (up to a 90-day supply) Generic Preferred Brand Non-Preferred Brand	 $30.00 $80.00 $120.00

Prescription Medication and Diabetic Supplies	Copayment
Retail (up to a 90-day supply)	
Generic	$37.50
Preferred Brand	$100.00
Non-Preferred Brand	$150.00

The Member must pay a portion of Covered Prescription Drugs to receive Prescription Drug Benefits. A copayment is that portion of Covered Prescription Drugs which you are required to pay under this benefit. The Prescription Drug Co-payment is considered an Eligible Expense under the medical portion of this Plan and accumulates toward the medical Plan Out-of-Pocket Maximum.

In addition to the Copayments, Members will be required to pay the Dispense as Written (DAW) penalty which is the difference in the medication cost of a generic medication versus a name-brand medication when the Member requests the brand name drug and the prescribing physician has indicated the generic equivalent substitution is allowable. The Plan will exclude Narrow Therapeutic Index drugs from the Copay DAW penalties. Narrow Therapeutic Index (NTI) drugs are medications which can cause side-effects or be ineffective should the normal blood concentrations fall outside of the therapeutic window. These have been reviewed by the PBM Pharmacy and Therapeutic Committee for inclusion. NTI drugs may include transplant medications, thyroid hormones, and some seizure medications.

No payment will be made under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.

DISPENSE AS WRITTEN or "DAW" are the rules associated with how the Plan will pay for a name-brand prescription that has a generic equivalent.

DAW1 – The drug is available as a generic, but the physician has requested that the brand be dispensed to the Member. The Member will be responsible for a generic copay plus the difference in cost between the brand drug and the generic drug.

DAW2 – The drug is available as a generic, but the Member has requested that the brand be dispensed. The Member will be responsible for a generic copay plus the difference in cost between the brand drug and the generic drug.

DAW3 – The drug is available as a generic, but the pharmacist has selected that the brand be dispensed. The Member will be responsible for a generic Copay plus the difference in cost between the brand drug and the generic drug.

DAW4 – The drug is available as a generic, but the generic is not in stock and the pharmacy dispenses the brand drug. The Member will be responsible for a generic Copay plus the difference is cost between the brand drug and the generic drug.

To avoid additional cost above the copayment amounts Members should ask their doctor to prescribe any available generic equivalent medications.

The Preferred Medication List (PML), also known as a formulary, is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are lower-cost generics and brand names that are available at a lower cost than their more expensive brand-name counterparts. The PML is updated quarterly, and as needed throughout the year to add significant new medications as they become available. Medications that no longer offer the best therapeutic value for the Plan are deleted from the PML once a year, and a letter is sent to any Member affected by the change. To see what medications are on the PML, log on to the PBM website or contact the Customer Service Center listed on your ID card. You may have a copy sent to you. Sharing this information with your doctor helps ensure that you are getting the medications you need, and saving money for both you and your Plan.

9.2 Covered Prescription Drugs

The term Covered Prescription Drugs means:

1. A Prescription Legend Drug for which a written prescription is required. A Legend Drug is one which has on its label "caution: federal law prohibits dispensing without a prescription";
2. Insulin; pre-filled insulin cartridges for the blind; oral blood sugar control agents;
3. Needles, syringes, glucose monitors, and machines, glucose test strips, visual reading ketone strips; urine test strips, lancets and alcohol swabs are all covered when dispensed by the mail order and retail pharmacy program;
4. A compound medication of which at least one ingredient is a Prescription Legend Drug;
5. Tretinoin for individuals through age 24, without prior authorization;
6. Oral contraceptives or contraceptive devices, regardless of intended use, except that implantable contraceptive devices, such as Norplant, are not considered Covered Prescription Drugs;
7. Prenatal vitamins, upon written prescription;
8. Growth hormones (with prior-authorization); or
9. Self-Injectable drugs or medicines for which a prescription is required, except injectable infertility drugs.

9.3 Limitations

No payment will be made for expenses incurred for the following:

1. For non-legend drugs, other than those specified under ''Covered Prescription Drugs'';
2. To the extent that payment is unlawful where the person resides when expenses are incurred;
3. For charges which the person is not legally required to pay;

4. For charges which would not have been made if the person were not covered by these benefits;
5. For experimental drugs or for drugs labeled: "Caution limited by federal law to investigational use";
6. For drugs which are not considered essential for the necessary care and treatment of a non-occupational Injury or Sickness, as determined by the Plan Administrator;
7. For drugs obtained from a non-Participating Pharmacy;
8. For any prescription filled in excess of the number specified by the Physician or dispensed more than one year from the date of the Physician's order;
9. For more than a 31-day supply when dispensed in any one Prescription Order through a Retail Pharmacy;
10. For more than a 90-day supply when dispensed in any one Prescription Order through a Participating Choice90 Retail Pharmacy or Mail-Order Pharmacy;
11. For indications not approved by the Food and Drug Administration;
12. For immunization agents, biological sera, blood, or blood plasma;
13. For therapeutic devices or appliances, support garments and other non-medicinal substances, excluding insulin syringes;
14. For drugs for cosmetic purposes;
15. For administration of any drug;
16. For medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
17. For prescriptions which an eligible person is entitled to receive without charge from any workers' compensation or similar law or any public program other than Medicaid;
18. For non-Medically Necessary anabolic steroids;
19. For anorexients;
20. Implantable contraceptive devices;
21. For prescription vitamins not recommended for coverage by the USPSTF and CDC;
22. For all medications administered for the purpose of weight loss/obesity;
23. For treatment of erectile or sexual dysfunction (both male and female);
24. For all injectable infertility drugs; or
25. Prescription medications that have over-the-counter (OTC) equivalents, other than those drugs recommended by USPSTF and CDC.

9.4 Specialty Pharmacy

Certain medications used for treating chronic or complex health conditions are handled through the PBM's Specialty Pharmacy Program.

The purpose of the Specialty Pharmacy Program is to assist you with monitoring your medication needs for conditions such as those listed below and providing patient education. The Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods, special storage, handling, and delivery.

Medications for these conditions through this Specialty Pharmacy Program include but are not limited to the following:

1. Cystic Fibrosis;
2. Multiple Sclerosis;
3. Rheumatoid Arthritis;
4. Prostate Cancer;
5. Endometriosis;
6. Enzyme replacement;
7. Precocious puberty;
8. Osteoarthritis;
9. Viral Hepatitis; or
10. Asthma

Medications in the Specialty Program may only be obtained through contracted retail pharmacies or through the PBM's home delivery service. You may contact the PBM to determine which retail pharmacies are contracted. Specialty medications are limited to a 30-day supply.

A Specialty Care Representative may contact you to facilitate your enrollment in the Specialty Program. Trained Specialty Care pharmacy staff is available 24 hours a day, 7 days a week to assist you or you may enroll directly into the program by calling the PBM's Customer Service Center.

9.5 Reimbursement/Filing a Claim

If you or your Dependent purchase Covered Prescription Drugs from a Participating Retail Pharmacy, you pay only the portion shown in the Schedule of Benefits at the time of purchase for covered medications. Should you need to obtain a Covered Prescription Drug prior to obtaining your Member ID card, you may file a claim form to obtain reimbursement. The claim form is available on the PBM's website.

If you or your Dependent purchases Covered Prescription Drugs from a Non-Participating Retail Pharmacy, you pay the full cost. These claims are considered not covered under any section of this Plan Description, unless the medication was obtained while traveling in a foreign country and was for an emergency. Claim forms and foreign travel guidelines are available on the PBM's website.

9.6 Travel within the United States

Benefits are covered in-network. You may contact the PBM customer service center listed in your ID card to locate a pharmacy in the area in which you are traveling.

9.7 International Travel

Prescriptions cannot be mailed outside of the U.S. You may receive a one-year supply for certain prescriptions through mail-order service prior to leaving the U.S. Please call the PBM

customer service center listed in your ID card to make arrangements. If you obtain non-emergency medications outside of the U.S., you will not be reimbursed.

9.8 Extended Vacation

Copayments will be the same as you would normally pay times the number of refills you need.

If your medication is lost, stolen, or damaged, replacement medication is not covered.

ARTICLE 10

EXCLUSIONS AND GENERAL LIMITATIONS

10.1 Exclusions and General Limitations

In addition to any services and supplies specifically excluded in any other Article of the Plan Description, any services and supplies which are not described as covered are excluded.

In addition, the following are specifically excluded Services and Supplies:

1. Charges for services filed with the Third Party Claim Administrator beyond the Timely Filing period.
2. Care for health conditions that are required by state or local law to be treated in a public facility.
3. Care required by state or federal law to be supplied by a public school system or school district.
4. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
5. Treatment of an illness or injury which is due to war, declared or undeclared.
6. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Plan.
7. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
8. Any services and supplies which are experimental, investigational or unproven. These services may be related to medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan to be:
    a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
    b. The subject of review or approval by an Institutional Review Board for the proposed use;
    c. The subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the Cancer Clinical Trials provision of this Plan under Covered Services and Supplies;) or

d. Not demonstrated, through existing peer reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

9. Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis depilation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function such as surgery required to repair bodily damage a person receives from an injury.
10. Non-life threatening complications of a non-covered cosmetic surgery are not covered. This includes, but is not limited to, subsequent surgery for reversal, revision or repair related to the procedure.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics including braces, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies for a continuous course of dental treatment started within six months of an accidental injury to sound natural teeth are covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. The following bariatric procedures are excluded: open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy and open adjustable gastric banding.
13. Unless otherwise included as a covered expense, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Physician or otherwise covered under the Plan under Covered Services and Supplies.
15. Reversal of voluntary sterilization procedures and voluntary termination of pregnancy.
16. Gender reassignment surgery.
17. Treatment of erectile dysfunction and sexual dysfunction.
18. Medical and hospital care and costs for the infant Child of a Dependent, unless this infant Child is otherwise eligible under the Plan.
19. Non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, and intellectual disabilities.

20. Therapy to improve general physical condition including, but not limited to, routine long term care.
21. Consumable medical supplies, including but not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the Inpatient Hospital Services, Outpatient Facility Services, Home Health Services, Diabetic Services and Supplies, or Breast Reconstruction, Ostomy Supplies and Breast Prostheses.
22. Private hospital rooms and/or private duty nursing are only available during inpatient stays and determined to be Medically Necessary by the Plan. Private duty nursing is available only in an inpatient setting when skilled nursing is not available from the facility. Custodial Nursing is not covered by the Plan.
23. Personal or comfort items such as television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
24. The following services are excluded: foot orthotics, corrective orthopedic shoes, and arch supports unless provided in the Diabetic Services and Supplies provision.
25. The following services and supplies are excluded: elastic/compression garments (except for treatment of lymphedema and burns), garter belts, corsets, dentures, wigs/hair pieces (exception when indicated for coverage in Section 8.25), hair transplants, and treatment of alopecia or hair loss.
26. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery); routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
27. Treatment by acupuncture.
28. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided by this Plan.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.
30. Membership costs or fees associated with health clubs, and weight loss programs.
31. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.
32. Services rendered for the purpose of home delivery.
33. Genetic testing and therapy including germ line and somatic unless determined Medically Necessary by the Plan for the purpose of making treatment decisions.
34. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Plan's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
35. Blood administration for the purpose of general improvement in physical condition.
36. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks, except as otherwise referenced in

this Plan Description. However, immunizations required for State of Arizona work related travel are covered by the Plan for all Members.

37. Cosmetics, dietary supplements, nutritional formula (except for treatment of malabsorption syndromes), and health and beauty aids.
38. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
39. Phase 3 Cardiac rehabilitation.
40. Massage therapy, health spas, mineral baths, or saunas.
41. Coverage for any services incurred prior to the effective date of the Member or after the termination date of the Member's coverage.
42. Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury.
43. To the extent that payment is unlawful where the person resides when the expenses are incurred.
44. To the extent of the exclusions imposed by any certification requirement.
45. Charges made by an assistant surgeon or co-surgeon in excess of the network contracted rate.
46. Charges for supplies, care, treatment or surgery which is not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by the Plan.
47. Manipulations under anesthesia except when determined to be Medically Necessary by the Third Party Claim Administrator.
48. Surgery for correction of Hyperhidrosis.
49. Any conditions Medicare identifies as Hospital-Acquired Conditions (HAC's), and or National Quality Forum (NQF) "Never Events".
50. Biofeedback except for Mental Health and Substance Abuse only for pain management.
51. Any medical treatment and/or prescription related to infertility once diagnosed.
52. The following Autism Spectrum Disorder services are excluded: Sensory Integration, LOVAAS Therapy and Music Therapy.
53. Purchase or rental of durable medical equipment and prosthetics are not covered when due to misuse, damage lost, or stolen.

In addition to the provisions of this Exclusions and Limitations section, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision under Article 8 of this Plan Description.

10.2 Circumstance Beyond the Plan's Control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Plan, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.

ARTICLE 11

COORDINATION OF BENEFITS AND OTHER SOURCES OF PAYMENT

11.1 Coordination of Benefits and Other Sources of Payment

Coordination of Benefits applies to medical services received under the terms of the Plan. Prescription medications are not subject to coordination of benefits. If you choose to obtain medications through coverage other than this Plan, amounts applied to deductible, copays, or coinsurance will not be reimbursed through this Plan.

Coordination of Benefits does not override Plan provisions, exclusions, or Pre-Certification/Prior Authorization requirements as noted in this Plan Description. All Plan terms and conditions apply whether this Plan is primary or secondary, including the requirement to receive all services through a network provider except as specifically noted in this Plan Description.

11.2 Workers' Compensation

Benefits under this Plan will not duplicate any benefit which the Member is entitled to receive under workers' compensation law. In the event the Plan renders or pays for health services which are covered by a workers' compensation plan or included in a workers' compensation settlement, the Plan shall have the right to receive reimbursement either:

1. Directly from the entity which provides Member's workers' compensation coverage; or
2. Directly from the Member to the extent, if any, that the Member has received payment from such entity, where the Plan pays for services which are within the scope of the "Covered Services and Supplies" section of the Plan.

The Plan shall have a right of reimbursement to the extent that the Plan has made payments for the care and treatment so rendered. In addition, it is the Member's obligation to fully cooperate with any attempts by the Plan to recover such expenses.

11.3 Coordination of Benefits

This section applies if you are covered under another plan besides this health Plan or are a new Retiree and determines how the benefits under the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

When coordinating benefits with Medicare for Retiree Members, the Benefit Options Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. All Retiree Plan Members who are eligible for Medicare Part B, should enroll in Medicare Part B so the Member does not assume the Part B claims costs. If a Plan Member who is eligible for Medicare Part B does not enroll in Medicare Part B, the Benefit Options Plan will only pay secondary benefits.

When enrolling on the Benefit Options Plan as a New Retiree and if eligible for Medicare Part B at the time of retirement, a grace period will be granted until the first of the month following the retirement date. If a Plan Member who is eligible for Medicare Part B does not enroll in Medicare Part B, the Plan will only pay secondary benefits after the grace period has expired.

If you are eligible to enroll in Medicare as an active Employee, Dependent, or Retiree because of End-Stage Renal Disease, the Plan will pay for the first 30 months to 33 months depending on the coordination period, whether or not you are enrolled in Medicare and have a Medicare card. At the end of the 30 months to 33 months depending on coordination period, Medicare becomes the primary payer. If a Plan Member who is eligible for Medicare Part B does not enroll in Medicare Part B, the Plan will only pay secondary benefits after 30 months to 33 months depending on coordination period of primary coverage. The length of the coordination period is based on the treatment plan; Members that are scheduled for transplant or have at-home dialysis have a 30-month coordination period, while Members who have regular dialysis (at a facility) have a 33-month coordination period.

The prescription drug coverage offered by the Benefit Options Plan is considered Creditable Coverage. If you decide to enroll in a separate Medicare Part D Plan, you will not be permitted to continue in this Plan.

11.4 Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

11.4.1. Plan

Any of the following that provides benefits or services for medical care or treatment:

1. Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public nor is individually underwritten, including closed panel coverage;
2. Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies; or
3. Medical benefits coverage of group, group type, and individual automobile contracts.

Each type of coverage you have in these three (3) categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefit rules, each of the parts shall be treated as a separate Plan.

11.4.2. Closed Panel Plan

A Plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

11.4.3. Primary Plan
The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

11.4.4. Secondary Plan
A Plan that determines and may reduce its benefits after taking into consideration copayments, coinsurance, deductibles, and the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

11.4.5. Allowable Expense
A necessary, customary, and reasonable health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you; but not including prescription medications obtained at a pharmacy, dental, vision or hearing care coverage. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

A plan which takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definitions of an Allowable Expense.

11.4.6. Claim Determination Period
The claim determination period corresponds to the Plan Year, but it does not include any part of a year during which you are not covered under this Plan or any date before this section or any similar provision takes effect.

11.4.7. Reasonable Cash Value
An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

11.5 Order of Benefit Determination Rules
A plan that does not have a coordination of benefits rule consistent with this section shall always be the primary plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation will be used:

1. The plan that covers you (the Employee, subscriber or Retiree) is primary and the plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    a. Secondary to the plan covering the person as a Dependent; and
    b. Primary to the plan covering the person as other than a Dependent (e.g. Employee or Retiree).

2. If you are a Dependent Child whose parents are not divorced or legally separated under a decree of dissolution of marriage or of separate maintenance, the primary plan shall be the plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or Employee.
3. If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
    a. First, if a court decree states that one parent is responsible for the Child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    b. Then, the plan of the parent with custody of the Child;
    c. Then, the plan of the Spouse of the parent with custody of the Child;
    d. Then, the plan of the parent not having custody of the Child;
    e. Finally, the plan of the Spouse of the parent not having custody of the Child; and
    f. If parents share joint custody and each parent is responsible for 50% of covered medical expenses, the Plan will coordinate 50% payment of benefits with the other parent's Plan.
4. The plan that covers you as an active Employee (or as that Employee's Dependent) shall be the primary plan and the plan that covers you as a laid-off or Retired Employee (or as that Employee's Dependent) shall be the secondary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
5. The plan that covers you under a right of continuation which is provided by federal or state law shall be the secondary plan and the plan that covers you as an active Employee or Retiree (or as that Employee's Dependent) shall be the primary plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
6. If one of the plans that covers you is issued out of the state whose laws govern this plan and determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended, except for Active State of Arizona Employees otherwise eligible under this Plan, however, when more than one plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

11.6 Effect on the Benefits of this Plan

If Benefit Options is the Secondary Plan, Benefit Options may reduce benefits so that the total benefits paid by all plans during a Claim Determination Period are not more than one hundred

(100%) percent of the total of all Allowable Expenses. All copays noted in the Schedule of Benefits remain the Member's responsibility and are not considered an Allowable Expense when this Plan is secondary.

For example:	
Claim filed for services in a physician's office	= $100
Medicare payment (including write-off)	= $ 90
Member copay	= $ 10
Plan payment	= $ 0
Claim filed for services in a physician's office	= $100
Medicare payment (including write-off)	= $ 70
Member copay	= $ 10
Plan payment	= $ 20

11.7 Recovery of Excess Benefits

If the Plan provides payment for services and supplies that should have been paid by a Primary Plan or if payment is made for services in excess of those for which the Plan is obligated to provide under this Plan, the Plan shall have the right to recover the actual payment made. When an overpayment is identified, the refund request will be initiated to the original payee of issued check. If the payee is the Provider, the Member will receive a copy of the letter. In the event the overpayment is not refunded to the Plan, the Third Party Claim Administrator may apply future claims to the balance of the overpaid amount.

The Plan shall have the sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If Benefit Options requests, the Member shall execute and deliver to us such instruments and documents as we determine are necessary to secure its rights.

11.8 Right to Receive and Release Information

The Plan, without consent of or notice to you, may obtain information from and release information to any Plan with respect to you in order to coordinate your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate your benefits pursuant to this section.

11.9 Injuries Covered under Med Pay Insurance

If you are injured as a result of a motor vehicle accident, and the medical expenses are covered in full or part by a medical payment provision under an automobile insurance policy (Med Pay Insurance), the Med Pay Insurance shall pay first, and the Plan shall pay only in the event the amount of Med Pay Insurance is insufficient to pay for those medical expenses.

The Plan reserves the right to require proof that Med Pay Insurance has paid the full amount required prior to making any payments.

Payment for such services and benefits shall be your responsibility. If the Plan paid in excess of their obligation, you may be asked to assist the Plan in obtaining reimbursement from Med Pay Insurance for expenses incurred in treating your injuries.

11.10 Subrogation and Right of Reimbursement Recovery

This provision applies whenever any payments are made pursuant to this Plan, to or for the benefit of any person covered by the Plan (for purposes of this provision only, such person shall be referred to herein as "Covered Person" and includes, but is not limited to the Covered Person's Dependents, Spouse, Children or other individuals in any way connected to the Covered Person to whom or for whose benefit any payments have been made under this Plan, the Member himself or herself, and all their heirs, legatees, administrators, executors, beneficiaries, successors, assigns, personal representatives, next friends, and any other representatives of such Covered Person). Such Covered Person has or may have any claim or right to recover any damages from any person or entity, including but not limited to, any tortfeasor, anyone vicariously liable for such tortfeasor, any tortfeasor's insurance company, any uninsured motorist insurance carrier, any underinsured motorist insurance carrier, and any others who are or may be liable for damages to the Covered Person (for purpose of this provision only, such person or entity shall hereinafter be collectively referred to as the "Third Party") as a result of any negligent or other wrongful act of anyone. In the event of any such payments under the Plan, the Plan shall, to the full extent of such payments, and in an amount equal to what the Plan paid, be subrogated to all rights of recovery of the Covered Person against such Third-Party. The Plan, either in conjunction with or independently of the Covered Person, shall be entitled to recover all such payments from the Third-Party. (This is the Plan's right of subrogation).

In addition to and separate from the above-described right of subrogation, in the event of any payments under the Plan to or for the benefit of any Covered Person, the Covered Person agrees to reimburse the Plan to the full extent of such payments, and in an amount equal to what the Plan paid, from any and all amounts recovered by the Covered Person from any Third Party by suit, settlement, judgment or otherwise, whether such recovery by the Covered Person is in part or full recovery of the damages incurred by the Covered Person. (This is the Plan's right of reimbursement.)

The above-described right of subrogation and right of reimbursement are not subject to offset or other reduction by reason of any legal fees or other expenses incurred by the Covered Person in pursuing any claim or right. The Plan is entitled to recover in full all such payments in subrogation and/or pursuant to the right of reimbursement first and before any payment whatsoever by the Third Party to or for the benefit of the Covered Person. The right of subrogation and/or right of reimbursement of the Plan supersedes any rights of the Covered Person to recover from any Third-Party, including situations where the Covered Person has not been fully compensated for all the Covered Person's damages. The priority of the Plan to be paid first exists as to all damages received or to be received by the Covered Person, and to any full or partial recovery by the Covered Person. The Covered Person agrees that the Covered

Person's right to be made whole is superseded by the Plan's right of subrogation and/or right of reimbursement.

The Covered Person agrees to fully cooperate with the Plan in any effort by the Plan to recover pursuant to its rights of subrogation and/or reimbursement, and the Covered Person further agrees to do nothing to prejudice such rights. The Covered Person agrees to provide information to the Plan necessary for the Plan to pursue such rights, and further agrees, if requested by the Plan, to acknowledge in writing the rights of the Plan to recover following any injury or illness giving rise to any payments under the Plan. If requested to do so by the Plan, the Covered Person agrees to assign in writing to the Plan the Covered Person's right to recover against any Third-Party without the Plan having been paid in full, then the Covered Person agrees to hold such payment in trust for the Plan and promptly notify the Plan in writing that the Covered Person is holding such funds and will release such funds to the Plan upon request by the Plan. The Covered Person further agrees to promptly notify the Plan in writing of the commencement of any litigation or arbitration seeking recovery from any Third-Party, and further agrees not to settle any claim against any Third-Party without first notifying the Plan in writing at least fourteen days before such settlement so the Plan may take actions it deems appropriate to protect its right of subrogation and/or right of reimbursement. In the event the Covered Person commences any litigation against any Third Party, the Covered Person agrees to name the Plan as a party to such litigation so as to allow the Plan to pursue its right of subrogation and/or right of reimbursement.

11.11 Statutory Liens

Arizona law prohibits Participating Providers from charging you more than the applicable copayment or other amount you are obligated to pay under this Plan for covered services. However, Arizona law also entitles certain Providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Provider may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member copayment plus what the Participating Provider has received from Plan as payment for covered services, and (2) the Participating Provider's full billed charges.

11.12 Fraud

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit will lose all benefit coverage under any Plan offered by ADOA. You will not be eligible to re-enroll at a future date. Amounts paid on these claims may be deducted from your pay until all funds have been reimbursed to ADOA.

ARTICLE 12

CLAIM FILING PROVISIONS AND APPEAL PROCESS

Medicare Part D participants have dual drug coverage. For drugs covered under Medicare Part D, the following does not apply, please refer to www.medicaregenerationrx.com/stateofaz. For drugs not covered under Medicare Part D the following applies.

12.1 Discretionary Authority

The Plan Sponsor delegates to the Third Party Claim Administrator the discretionary authority to apply Plan terms and to make factual determinations in connection with its review of claims under the Plan. Such discretionary authority is intended to include, but not be limited to, the computation of any and all benefit payments. The Plan Sponsor also delegates to the Third Party Claim Administrator the discretionary authority to perform a full and fair review of each claim denial which has been appealed by the claimant or his duly authorized representative.

12.2 Claims Filing Procedure

The following claim definitions have special meaning when used in this Plan in accordance with Claim Procedures and Appeal Procedures.

"Claim" is any request for a Plan benefit or benefits made by a Member or by an authorized representative of the Member in accordance with the Plan's procedures for filing benefit claims.

"Urgent Care Claim" is a claim for medical care to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant's life, health or ability to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care that is the subject of the claim. If the treating Physician determines the claim is "urgent," the Plan must treat the claim as urgent.

"Pre-Service Claim" is a request for approval of a benefit in which the terms of the Plan condition the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Examples of a Pre-Service Claim include but are not limited to a Pre-Certification/Prior Authorization of general items or health services or a request for Pre-Determination to determine coverage for a specific procedure.

"Post-Service Claim" is a claim that under this Plan is not a Pre-Service Claim (i.e., a claim that involves consideration of payment or reimbursement of costs for medical care that has already been provided).

Requests for determinations of eligibility or general inquiries to the availability of particular Plan benefits or the circumstances under which benefits might be paid under the terms of the Plan will not be treated as a claim for benefits for the purposes of the Claim Procedures.

"Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

12.3 Notice of Claim – Post-Service Claims

In order to promptly process Post-Service Claims and to avoid errors in processing that could be caused by delays in filing, a written proof of loss should be furnished to the Third Party Claim Administrator as soon as reasonably possible. In no event, except in the absence of legal incapacity of the claimant, may proof be furnished later than one (1) year from the date upon which an expense was incurred. Except as indicated in the preceding sentence, Post-Service Claims will be barred if proof of loss (filing initial claim) is not furnished within one (1) year from the date incurred.

It is the responsibility of the Member to make certain each Post-Service Claim submitted by him or on his behalf includes all information necessary to process the claim, and that the Post-Service Claim is sent to the proper address for processing (the address on the Member's ID Card). If a Post-Service Claim lacks sufficient information to be processed, or is sent to an incorrect address, the Post-Service Claim will be denied.

12.4 Initial Claim Determination

Provided a Member files a claim for benefits in accordance with the terms of the Plan specific to each type of claim, the Plan will make an initial claim determination:

1. Within 3 business days after receipt of an Urgent Care Claim by the Plan. This notice if adverse, must be provided to you in writing within 3 days of any oral communication;
2. Within 15 calendar days after receipt of a Pre-Service Claim by the Plan. This notice if adverse, must be provided in writing;
3. Within 30 calendar days after receipt of a Post-Service Claim by the Plan.

The time periods above are considered to commence upon the Third Party Claim Administrator receipt of a claim for benefits filed in accordance with the terms of the Plan specific to each type of claim, without regard to whether all of the information necessary to decide the claim accompanies the filing.

If a claim on review is wholly or partially denied, the written notice will contain the following information:

1. The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to the Member free of charge upon request. If the claim was denied because it does not meet the definition of a Covered Expense or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Member's medical circumstances can be provided free of charge to the Member upon request, including the names of any medical professionals consulted during the review process.
2. A description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;
3. A statement that the Member is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Member's claim.
4. For a denial involving urgent care claim, the notice will also include a description of the expedited review process for such claims. The notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 business days after the oral notice.
5. For medical claims, the notice will also include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount and the denial code. Further, the denial notice will include the following information (a) a statement that diagnosis and treatment codes are available upon request, (b) a description of the standard used in denying the claim, (c) a description of the external review process, and (d) the availability of, and contact information for, any applicable office of insurance consumer or ombudsman to assist enrollees with internal claims and appeals and external review processes.
6. A statement notifying the Member about further appeal processes available, as established by the Third Party Claim Administrator.

12.5 Concurrent Care Decisions

Any decision by the Plan to terminate or reduce benefits that have already been granted with the potential of causing disruption to ongoing care, course of treatment, number of treatments or treatments provided as a Covered Expense before the end of such treatments shall constitute a denied claim. The Plan will provide a Member with notice of the denial at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review before the benefit is reduced or terminated. The written notice of denial will contain the information outlined above.

Any Urgent Care Claim requesting to extend an Inpatient admission beyond the initial period approved during the Pre-Certification/Prior Authorization process, must be decided within 24 hours provided that the claim is made at least 24 hours prior to the expiration of the initially prescribed period. Notification will be provided in accordance with the Urgent Care Claim notice requirements outlined above.

Any Urgent Care Claim requesting to extend an outpatient course of treatment beyond the initially prescribed period of time, or number of treatments, must be decided within 3 business days. Notification will be provided in accordance with the Urgent Care Claim notice requirements outlined above.

12.6 Incomplete Urgent Care Claims Notification

In the case of an Urgent Care Claim, if additional information is required to make a claim determination, the Plan will provide the Member notification that will include a description of the information needed to complete the claim. This notice must be provided within 24 hours after receipt of the claim for an inpatient admission and 3 business days for outpatient services. The Member shall be afforded at least 48 hours from receipt of the notice in which to provide the specified information. The Plan shall make its initial determination as soon as possible, but in no case later than 48 hours after the earlier of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the Member to provide the specified additional information.

12.7 Extensions of Time

The Plan may extend decision-making on both Pre-Service Claims and Post-Service Claims for one additional period of 15 days after expiration of the relevant initial period. Provided the Third Party Claim Administrator determines that an extension is necessary for reasons beyond control and the Plan notifies the Member prior to the expiration of the relevant initial period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the notice of extension is provided, a Member shall be afforded at least 45 days from receipt of the notice to respond. There is no extension permitted in the case of Urgent Care Claims.

12.8 Required Filing Procedures for Pre-Service Claims

In the event a Member or authorized representative of the Member does not follow the Plan's claim filing procedures for a Pre-Service Claim, the Plan will provide notification to the Member or authorized representative accordingly. For all Pre-Service Claims, the Plan must notify the Member or authorized representative, of failure to follow filing procedures within 5 calendar days (24 hours in the case of a failure to follow filing procedures for an Urgent Care Claim). Notification by the Plan may be oral unless written notification is requested by the Member or authorized representative. The notification of failure to follow filing procedures for Pre-Service Claims will apply only when a communication is received from a Member or health care professional representing the Member that specifies the identity of the Member, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, and the communication is received by the Third Party Claim Administrator.

12.9 Claims Appeal Procedures

In cases where a claim for benefits payment is denied in whole or in part, the Member may appeal the denial. This appeal provision will allow the Member to:

1. Request from the Plan a review of any claim for benefits. Such request must include:
    a. Employee name;

   b. Covered Employee's Member ID;
   c. Name of the patient; and
   d. Group/Client Identification number from the Member's ID card.
2. Request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.
3. Submit written comments, documents, records, and other information relating to the claim.
4. Request, free of charge, reasonable access to documents, records, and other information relevant to the Member's claim. A document, record or other information is considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The initial request for review must be directed to the Third Party Claim Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits. In the case of Urgent Care Claims, a request for an expedited review may be submitted orally and all necessary information, including the Plan's benefit determination upon review, may be transmitted between the Plan and Member via telephone, facsimile, or other available similarly expeditious methods. Expedited appeals may be filed orally by calling the Third Party Claim Administrator Customer Service Center.

Upon request, the Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with the denial, without regard to whether the advice was relied on in making the denial.

The review of the denial will be made by the Third Party Claim Administrator, or by an appropriate named fiduciary who is neither the party who made the initial claim determination nor the subordinate of such party. The review will not defer to the initial claim determination and will take into account all comments, documents, records and other information submitted by the Member without regard to whether such information was previously submitted or relied upon in the initial determination. In deciding an appeal of any denied claim that is based in whole or in part on a medical judgment, the Plan must consult with an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied claim that is the subject of the appeal nor the subordinate of any such individual.

The Third Party Claim Administrator will ensure that all claims and internal appeals for medical benefits are handled impartially. The Third Party Claim Administrator shall ensure the independence and impartiality of the persons involved in making the decision. Accordingly,

decisions regarding hiring, compensation, termination promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support an adverse benefit determination. The Third Party Claim Administrator shall ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to deciding an appeal, the Third Party Claim Administrator must provide the claimant with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim.

In connection with an internal appeal of a medical claim, a claimant shall be able to review his or her file and present information as part of the review. Before making a benefit determination on review, the Third Party Claim Administrator shall provide the claimant with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision. The claimant shall be given this information in advance of the date on which the notice of final appeal decision is made to give such claimant a reasonable opportunity to respond.

For medical claims, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to the claim, the claimant is deemed to have exhausted the internal claims and appeals process and may request an expedited external review before the Plan's internal appeals process has been completed. However, this shall not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, the claimant may resubmit the claim for internal review and the claimant may ask the Plan to explain why the error is minor and why it meets this exception.

The Third Party Claim Administrator will provide the Member with a written response:

1. Within 3 business days after receipt of the Member's request for review in the case of Urgent Care Claims;
2. Within 15 calendar days after receipt of the Member's request for review in the case of Pre-Service Claims;
3. Within 30 calendar days after receipt of the Member's request for review in the case of Post-Service Claims.

If a claim on review is wholly or partially denied, the written notice will contain the following information:

1. The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is

available to the Member free of charge upon request. If the claim was denied because it does not meet the definition of a Covered Health Service or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Member's medical circumstances can be provided free of charge to the Member upon request, including the names of any medical professionals consulted during the review process.

2. A statement that the Member is entitled to request, free of charge, reasonable access to all documents, records, and other information relevant to the Member/Participant's claim.
3. For a denial involving urgent care, the notice will also include a description of the expedited review process for such claims. The notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 business days after the oral notice.
4. For medical claims, the notice will also include information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount and the denial code. Further, the denial notice will include the following information (a) a statement that diagnosis and treatment codes are available upon request, (b) a description of the standard used in denying the claim, (c) a description of the external review process, and (d) the availability of, and contact information for, any applicable office of health insurance consumer or ombudsman to assist enrollees with internal claims and appeals and external review processes.
5. A statement notifying the Member about potential alternative dispute resolution methods, if any.

12.10 Levels of Standard Appeal and Responsibility of Review

Level 1 is an initial appeal filed by the Member in regard to a denial of services. The Level 1 appeal must be filed within 180 days from the claim denial date. Level 1 appeal are reviewed and responded to by the Third Party Claim Administrator. The staff person reviewing the appeal will not be the person who made the initial decision.

Level 2 is a second appeal filed by the Member in regard to a denial of services in which the denial was upheld during the review of the Level 1 appeal. The Level 2 appeal must be filed within 60 days of the Level 1 denial. Level 2 appeals are reviewed and responded to by the Third Party Claim Administrator. The staff person reviewing the appeal will not be the person who made the initial decision nor the Level 1 appeal decision.

Level 3 is the third appeal filed by the Member in regard to a denial of services in which the denial was upheld during the review of the Level 2 appeal. The Level 3 appeal must be filed within 60 days of the Level 2 denial. Level 3 appeals are reviewed by an accredited Independent Review Organization (IRO) as required under federal law at no charge to the Member.

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the IRO must consider when conducting the External Review. Within one (1) business day after making the decision, the IRO must notify you, Third Party Claims Administrator and the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. Your medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
4. The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by Third Party Claims Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the Final External Review Decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver the notice of Final External Review Decision to you, Third Party Claims Administrator and the Plan.

After a Final External Review Decision, the IRO must maintain records of all claims and notices associated with the External Review process for six years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited Independent Review
The Plan must allow you to request an expedited Independent Review at the time you receive:

1. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
2. A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited Independent Review, Third Party Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard External Review. Third Party Claims Administrator must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to IRO
Upon a determination that a request is eligible for External Review following preliminary review, Third Party Claims Administrator will randomly assign an IRO. The IRO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you, Third Party Claims Administrator and the Plan.

12.11 Pharmacy Appeals

Medicare Part D participants have dual drug coverage. For drugs covered under Medicare Part D, the following does not apply, please refer to www.medicaregenerationrx.com/stateofaz. For drugs not covered under Medicare Part D the following applies.

If you are dissatisfied with any service received under this Prescription Drug Benefit, you are encouraged to contact the PBM Customer Service Center. Frequently, your concern can be resolved with a telephone call to a Member Service Representative. If the Customer Service Center cannot resolve your concern, you may proceed to the Appeals Procedures as set forth above by contacting the Third Party Claim Administrator. Examples of concerns include, but are not limited to, quality of service received, the design of the prescription drug benefit plan, denial of a clinical authorization of a drug, payment amount, or denial of a claim issue.

12.12 Limitation

No action at law or in equity can be brought to recover on this Plan until the appeals procedure has been exhausted as described in this Plan.

No action at law or in equity can be brought to recover after the expiration of two (2) years after the time when written proof of loss is required to be furnished to the Third Party Claim Administrator.

ARTICLE 13

ADMINISTRATION

13.1 Plan Sponsor's Responsibilities

The Plan Sponsor shall have the authority and responsibility for:

1. Calling and attending the meetings at which this Plan's funding policy and method are established and reviewed;
2. Establishing the policies, interpretations, practices and procedures of this Plan and issuing interpretations thereof;
3. Hiring all persons providing services to this Plan;
4. To decide all questions of eligibility;
5. Receiving all disclosures required of fiduciaries and other service providers under federal or state law; and
6. Performing all other responsibilities allocated to the Plan Sponsor in the instrument appointing the Plan Sponsor.

13.2 Third Party Claim Administrator's Responsibilities

The Third Party Claim Administrator shall have the authority and responsibility for:

1. Acting as this Plan's agent for the service of legal process;
2. Applying this Plan's provisions relating to coverage, including when a claimant files an appeal with the Third Party Claim Administrator;
3. Administering this Plan's claim procedures;
4. Rendering final decisions on review of claims as required by the application of this Plan Description;
5. Processing checks for Benefits in accordance with Plan provisions;
6. Filing claims with the insurance companies, if any, who issue stop loss insurance policies to the Plan Sponsor; and
7. Performing all other responsibilities delegated to the Third Party Claim Administrator in the instrument appointing the Third Party Claim Administrator.

The Third Party Claim Administrator acting as the claims fiduciary will have the duty, power, and authority to apply the provisions of this Plan, to make factual determinations in connection with its review of claims under the Plan, and to determine the amount, manner, and time of payment of any Benefits under this Plan. All applications of the provisions of this Plan, and all determinations of fact made in good faith by the Third Party Claim Administrator, will be final and binding on the Members and beneficiaries and all other interested parties.

13.3 Advisors to Fiduciaries

A named fiduciary or his delegate may retain the services of actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to render advice concerning any responsibility such fiduciary has under this Plan.

13.4 Multiple Fiduciary Functions

Any named fiduciary may serve in more than one fiduciary capacity with respect to this Plan.

13.5 Notice of Appointments or Delegations

A named fiduciary shall not recognize or take notice of the appointment of another named fiduciary, or the delegation of responsibilities of a named fiduciary, unless and until the Plan Sponsor notifies the named fiduciary in writing of such appointment or delegation. The named fiduciaries may assume that an appointment or delegation continues in effect until the named fiduciary receives written notice to the contrary from the Plan Sponsor.

13.6 Written Directions

Whenever a named fiduciary or delegate must or may act upon the written direction of another named fiduciary or delegate, the named fiduciary or delegate is not required to inquire into the propriety of such direction and shall follow the direction unless it is clear on its face that the actions to be taken under that direction would be prohibited under the terms of this Plan. Moreover, such named fiduciary or delegate shall not be responsible for failure to act without written directions.

13.7 Co-Fiduciary Liability

A fiduciary shall not have any liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or, through his negligence in performing his own specific fiduciary responsibilities, enables such other fiduciary to commit a breach of the latter's fiduciary duty.

13.8 Action by Plan Sponsor

Any authority or responsibility allocated or reserved to the Plan Sponsor under this Plan may be exercised by any duly authorized officer of the Plan Sponsor.

ARTICLE 14

LEGAL NOTICES

14.1 HIPAA Privacy Regulation Requirements

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Plan Sponsor and other parties as necessary to determine appropriate processing of claims.

Please refer to the Benefit Options Guide for details on the use of PHI.

14.2 Notice of Special Enrollment Rights for Health Plan Coverage

If you decline enrollment in the State of Arizona's health plan for you or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you or your Dependents maybe able to enroll in the State of Arizona Employee's health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new Dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the State of Arizona's health plan if you become eligible for a state premium assistance program under Medicaid of CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your Dependent becomes eligible for special enrollment rights, you may add the Dependent to your current coverage or change to another health plan.

14.3 Patient Protection & Affordable Care Act (PPACA) Notices

Notice of Rescission

Under the PPACA, Benefit Services Division cannot retroactively cancel or terminate an individual's coverage, except in cases of fraud and similar situations. In the event that the Benefit Services Division rescinds coverage under the allowed grounds, affected individuals must be provided at least 30 days advanced notice.

Form W-2 Notice

Pursuant to the PPACA for tax years starting on and after January 1, 2012, in addition to the annual wage and tax statement employers must report the value of each employee's health coverage on form W-2, although the amount of health coverage will remain tax-free.

Notice about the Summary of Benefits and Coverage (SBC) and Uniform Glossary

On February 9, 2011, as part of the Affordable Care Act (ACA), the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations require group health plans and health insurance issuers that offer coverage for groups and individuals to provide access to the SBC and Uniform Glossary effective October 22, 2012. The SBC documents along with the uniform glossary will be posted electronically to the Benefit Options Website www.benefitoptions.az.gov. You may also contact Benefit Services to obtain a copy.

Notice of Nondiscrimination

Benefit Options complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Benefit Options provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, contact:

ADOA Benefit Services Division
100 N. 15th Avenue, Suite 260
Phoenix, AZ 85007
602-542-5008 or 1-800-304-3687, or email BenefitsIssues@azdoa.gov

If you believe that we have failed to provide these services or discriminated based on a protected class noted above, you can also file a grievance with ADOA Benefit Services Division.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of

Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏇ ᎮᏢ ᏗᏟᏃᏢᏗ ᏗᏎᏍᏗ ᏥᎪᏜᎳ ᎢᏞ ᏀᏉᏢ ᏁᎯ ᎮᏒ ᏗᎫᏗᏁᏗ ᎠᏟᏍᏁᏗ ᏆᎾᏲᏍᏗᎢ, ᎣᏉᎾᏡᏍᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga

	ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711 ·
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kama‘ilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free

	nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は711です。
28. Karen	[illegible] 0 [illegible].TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە TTY 711.
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meļeļe ilo kajin eo aṃ ilo ejjeļọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.

36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711
40. Pennsylvanian Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ ਨੰਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa’asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa’amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa’atalosagaina se tagata fa’aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni

	i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Dum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo''u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	[illegible] [illegible] TTY 711. 0
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711

59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá òǵbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

14.4 General COBRA Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other Members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Benefit Services Division.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be

offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee become entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child"

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Benefit Options Plan, and that bankruptcy results in a loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a qualified beneficiary. The Retired Employee's Spouse, Surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

14.5 Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because the Plan health plan offers coverage for mastectomies, WHCRA applies to the Plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan.

14.6 Newborns' and Mothers' Protection Act of 1996 Notice

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or her newborn earlier. Also, under federal law, plans and insurers may not set the lever of benefits or out-of-pocket costs so that any later portion of the 48-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. If you have any questions, contact Benefit Options at 602 542 5008 or 1 800 304 3687 or email Benefit Options at BenefitIssues@azdoa.gov.

ARTICLE 15

MISCELLANEOUS

15.1 State Law

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law.

15.2 Status of Employment Relations

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the Employer and its Employees or to be consideration for, or an inducement or condition of, the employment of an Employee. Nothing in this Plan shall be deemed to:

1. Affect the right of the Employer to discipline or discharge any Employee at any time.
2. Affect the right of any Employee to terminate his employment at any time.
3. Give to the Employer the right to require any Employee to remain in its employ.
4. Give to any Employee the right to be retained in the employ of the Employer.

15.3 Word Usage

Whenever words are used in this Plan Description in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neutral form. The words "you" and "your" refer to Eligible persons as defined in Article 17.

Capitalized words in this Plan Description have special meanings and are defined in Article 17.

15.4 Titles are Reference Only

The titles are for reference only. In the event of a conflict between a title and the content of a section, the content of a section shall control.

15.5 Clerical Error

No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any Benefits paid will be made.

ARTICLE 16

PLAN IDENTIFICATION

1. Name of Plan: State of Arizona Group Health Plan
   AZ Benefit Options

2. Name and Address of Plan Sponsor:
   Arizona Department of Administration
   Benefit Services Division
   100 N 15th Avenue, Suite 260
   Phoenix, AZ 85007

3. Third Party Claim Administrators:

Medical Vendors	Aetna	Blue Cross Blue Shield of Arizona	CIGNA Health Care	UnitedHealthcare Insurance Company
Claims Address	PO BOX 14079 Lexington, KY 40512-4079	PO Box 2924 Phoenix, AZ 85062-2924 For chiropractic services: American Health Specialty Health Networks, Inc. Claims Administration PO Box 509001 San Diego, CA 92150-9001	PO BOX 188050 Chattanooga, TN 37422-8050	UnitedHealthcare PO BOX 30884 Salt Lake City, UT 84130
Appeals/ Correspondence Address	Attn: National Account CRT PO Box 14463 Lexington, KY 40512	Blue Cross Blue Shield of Arizona Medical Appeals and Grievances / Transplant Travel and Lodging Claims / Cruise Ship Claims PO Box 13466 Phoenix, AZ 85002-3466 For disputes over chiropractic care: American Specialty Health Networks, Inc. Appeals Coordinator PO Box 509001 San Diego, CA 92150-9001	CIGNA HealthCare Inc. National Appeals Unit PO Box 5225 Scranton, PA 18505-5225	UnitedHealthcare P.O. Box 740816 Atlanta, GA 30374-0816
Phone	866-217-1953	866-287-1980	800-968-7366	800-896-1067
Fax	859-455-8650	602-864-3102	888-999-1459	801-567-5498
TDD/TTY	800-628-3323	Maricopa county: 602-864-4823 Statewide: 800-232-2345, Ext 4823	Hearing impaired Members are encouraged to use the TRS (Telecommunications Relay Service) by dialing 711 from their phone or TTY.	800-896-1067
Website	www.aetna.com	www.azblue.com	www.cigna.com/stateofaz	www.myuhc.com
Policy Number	476687	30855	3331993	705963

Pharmacy Vendor	MedImpact	MedicareGenerationRx
Claims Address	10680 Treena Street San Diego, CA 92103	Attn: Claims Department PO Box 509099 San Diego, CA 92150
Appeals/Correspondence Address	Attn: Appeals Coordinator 10680 Treena St 5th Floor San Diego, CA 92131	Attn: Appeals Department PO Box 509099 San Diego, CA 92150
Phone	888-648-6769	877-633-7943
Fax	858-621-5147	858-790-6060
Website	www.benefitoptions.az.gov	www.MedicareGenerationRx.com/stateofaz
Bin Number	003585	015574
Retail PCN Number	28914	ASPROD1

4. Sponsor Identification Number: 86-6004791

5. Type of Benefits Provided: See Schedule of Benefits

6. Type of Plan Administration: Self-Funded Third Party

7. Third Party Claim Administrators/Agent for Legal Process/Named Fiduciary:

Medical Vendors	Aetna Life Insurance Company	Blue Cross Blue Shield of Arizona	CIGNA Health Care	UnitedHealthcare Insurance Company
Address	151 Farmington Ave. Hartford, CT 06156	2444 W. Las Palmaritas Dr. Phoenix, AZ 85021-4883	11001 N. Black Canyon Highway Phoenix, AZ 85029	450 Columbus Blvd. Hartford, CT 06103

Pharmacy Vendor	MedImpact	MedicareGenerationRx
Address	10680 Treena Street San Diego, CA 92103	PO Box 509099 San Diego, CA 92150

8. Funding to Plan: Contributions for this Plan are provided partially by contributions of the Plan Sponsor and partially by contributions of Covered Employees.

9. End of Plan's Year: December 31st of each year.

ARTICLE 17

DEFINITIONS

This section contains definitions of words and phrases which are contained within this Plan Description. Inclusion of medical service definitions does not imply that expenses related to those services are covered under the Plan.

ACCIDENT shall mean a specific, sudden, and unexpected event occurring by chance and resulting in bodily strain or harm.

AGENCY shall mean a department, university, board, office, authority, commission, or other governmental budget unit, of the State of Arizona.

AGENCY LIAISON shall mean the individual within each agency designated as the local Benefit Options representative.

ALCOHOLISM TREATMENT FACILITY shall mean a facility, providing inpatient or outpatient treatment for alcoholism, which is approved by the Joint Commission on Accreditation of Hospitals or certified by the health department of the state where it is located. Such a facility must also have in effect plans for utilization review and peer review.

AMBULANCE shall mean a vehicle for transportation of sick and/or injured persons equipped and staffed to provide medical care during transport.

AMBULATORY SURGICAL CENTER shall mean a licensed public or private facility which is primarily engaged in performing surgical procedures and which meets all of the following criteria:

1. Has an organized staff of physicians;
2. Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
3. Has continuous physician services and registered professional nursing services whenever a patient is in the facility; and
4. Does not provide services or other accommodations for patients to stay overnight.

AMENDMENT shall mean a formal document that changes the provisions of this Plan Description, duly signed by the authorized person(s) as designated by the Plan Sponsor.

APPLIED BEHAVIOR ANALYSIS THERAPIST shall mean a qualified therapist if all of the following is met:

1. Is certified by the Behavior Analyst Certification Board as either a:

- Board Certified Behavior Analyst
- Board Certified Associate Behavior Analyst

2. Is approved by medical management based on a combination of education, experience, and other qualifications.
3. An ABA therapist is QUALIFIED if he/she is approved by medical management based on a combination of education, experience, and other qualifications.
4. To ensure Plan coverage, qualifications of ABA providers must be established prior to receipt of services.

ARIZONA ADMINISTRATIVE CODE (A.A.C.) shall mean administrative rules promulgated by state agencies to govern the implementation of statutory intent and requirements.

ARIZONA REVISED STATUTE (A.R.S.) shall mean a law of the State of Arizona.

AUTISM SPECTRUM DISORDER shall mean one of the three following:

1. Autistic Disorder
2. Asperger's Syndrome
3. Pervasive Developmental Disorder – Not otherwise specified

BEHAVIORAL HEALTH FACILITY/CENTER shall mean a facility approved by a facility providing services under a community mental health or rehabilitation board established under state law, or certified by the health department of the state where it is located. Such a facility must also have in effect plans for utilization review and peer review.

BEHAVIORAL THERAPY shall mean interactive therapies derived from evidence based research, including applied behavior analysis, which includes discrete trail training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

BENEFIT shall mean the payment or reimbursement by this Plan of all or a portion of a medical expense incurred by a participant.

BILATERAL SURGICAL PROCEDURE shall mean any surgical procedure performed on any paired organ whose right and left halves are mirrored images of each other, or in which a median longitudinal section divides the organ into equivalent right and left halves. Surgery on both halves is performed during the same operative session and may involve one or two surgical incisions.

BIRTHING CENTER shall mean a licensed outpatient facility which provides accommodations for childbirth for low-risk maternity patients. The birthing center must meet all of the following criteria:

1. Has an organized staff of certified midwives, physicians, and other trained personnel;
2. Has necessary medical equipment;

3. Has a written agreement to transfer to a hospital if necessary; and
4. Is in compliance with any applicable state or local regulations.

BODY MASS INDEX (BMI) shall mean a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

CHILD shall mean a person who falls within one or more of the following categories:

1. A natural Child, adopted child, stepchild, or foster Child of the Member who is younger than age 26;
2. A Child who is younger than age 26 for whom the Member has court-ordered guardianship;
3. A Child who is younger than age 26 and placed in the Member's home by court order pending adoption; or
4. A natural Child, adopted Child, stepchild, or foster Child of the Member who has a disability prior to age 26 and continues to have a disability under 42 U.S.C. 1382c, who is dependent for support and maintenance upon the Member, and for whom the Member had custody prior to age 26.

COBRA shall mean the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended. This is a federal law requiring employers to offer continued health insurance coverage to Employees and Dependents whose group health coverage has terminated.

CODE shall mean the United States Internal Revenue Code of 1986, as amended.

COINSURANCE shall mean a percentage of the covered expenses for which each participant is financially responsible. Coinsurance applies after the deductible has been met.

COPAY or COPAYMENT shall mean a portion of the covered expenses for which the participant is financially responsible. Copayments are generally collected at the time of service or when billed by the Provider.

COSMETIC SERVICE shall mean a service rendered for the purpose of altering appearance, with no evidence that the service is Medically Necessary. Cosmetic service as noted in exclusions shall not include services or benefits that are primarily for the purpose of restoring normal bodily function as may be necessary due to an accidental injury, surgery, or congenital defect.

COST-EFFECTIVE shall mean the least expensive equipment that performs the necessary function.

COVERED SERVICE shall mean a service which is Medically Necessary and eligible for payment under the Plan.

CREDITABLE COVERAGE shall mean a Medical Plan that offers a prescription plan which is expected to pay out as much as standard Medicare prescription coverage pays, and is therefore considered Creditable Coverage. Members are not permitted to enroll in a separate Part D plan and continue in the medical Plan as it is considered Creditable Coverage.

CUSTODIAL CARE shall mean the care generally provides assistance in performing activities of daily living (ADL), (e.g., assistance walking, transferring in and out of bed, bathing, dressing, using the toilet, and preparation of food, feeding and supervision of medication that usually can be self-administered). Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. Also can be defined as the following:

- Custodial care is that care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care.
- Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.
- Custodial care essentially is personal care that does not require the continuing attention or supervision of trained, medical or paramedical personnel.
- Custodial care is maintenance care provided by family Members, health aids or other unlicensed individuals after an acute medical event when an individual has reached the maximum level of physical or mental function and is not likely to make further significant improvement.
- In determining whether an individual is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

DAY shall mean calendar day; not 24-hour period unless otherwise expressly noted.

DEDUCTIBLE shall mean the amount of covered expenses the participant must pay each Plan Year before benefits are payable by the Plan.

DEPENDENT see ELIGIBLE DEPENDENT.

DURABLE MEDICAL EQUIPMENT shall mean equipment purchased for treatment/accommodation of a non-occupational medical condition which meets all of the following criteria:

1. Is ordered by a physician in accordance with accepted medical practice;
2. Is able to resist wear and/or decay and to withstand repeated usage;
3. Appropriate for use in the home; and

4. Is not useful in the absence of illness or injury.

EFFECTIVE DATE shall mean the first day of coverage.

ELECTED OFFICIAL shall mean a person who is currently serving in office.

ELIGIBLE DEPENDENT shall mean the Member's Spouse or child who is lawfully present in the U.S.

ELIGIBLE EMPLOYEE shall mean an individual who is hired by the state, including the state universities, and who is regularly scheduled to work at least 20 hours per week for at least 90 days. Eligible Employee does not include:

1. A patient or inmate employed at a state institution;
2. A non-state employee, officer or enlisted personnel of the National Guard of Arizona;
3. A Seasonal, Temporary, or Variable Hour Employee, unless the Employee is determined to have been paid for an average of at least 30 hours per week using a 12-month measurement period;
4. An individual who fills a position designed primarily to provide rehabilitation to the individual;
5. An individual hired by a state university or college for whom the state university or college does not contribute to a state-sponsored retirement plan unless the individual is:
   a. A non-immigrant alien employee;
   b. Participating in a medical residency or post-doctoral training program;
   c. On federal appointment with cooperative extension;
   d. A Retiree who has returned to work under A.R.S. § 38-766.01.

Persons working for participating political subdivisions may also be considered Eligible Employees under the respective political subdivision's personnel rules.

ELIGIBLE FORMER ELECTED OFFICIAL shall mean an elected official as defined in A.R.S. § 38-801(3) who is no longer in office and who falls into one of the following categories:

1. Has at least five years of credited service in the Elected Officials' Retirement Plan;
2. Was covered under a group health or group health and accident plan at the time of leaving office;
3. Served as an elected official on or after January 1, 1983; and
4. Applies for enrollment within 31 days of leaving office or retiring.

ELIGIBLE RETIREE shall mean a person who is retired under a state-sponsored retirement plan and has been continuously enrolled in the Plan since time of retirement or a person who receives long-term disability benefits under a state-sponsored plan.

EMERGENCY shall mean a medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

EMPLOYEE see ELIGIBLE EMPLOYEE.

EMPLOYER shall mean the State of Arizona, one of the state universities, or a participating political subdivision.

ENROLLMENT FORM shall mean a paper form supplied by Benefit Options, a COBRA enrollment form, or an authorized self-service enrollment system.

EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN CHARGES shall mean charges for treatments, procedures, devices or drugs which the Medical Vendor, in the exercise of its discretion, determines are experimental, investigative, or done primarily for research. The Medical Vendor shall use the following guidelines to determine that a drug, device, medical treatment or procedure is experimental or investigative:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved for experimental use by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. Reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigative arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

EXPLANATION OF BENEFITS shall mean a statement sent to participants by the Medical Vendor following payment of a claim. It lists the service(s) that was/were provided, the allowable

reimbursement amount(s), amount applied to the participant's deductible, and the net amount paid by the Plan.

EXTENDED CARE FACILITY/SKILLED NURSING FACILITY shall mean an institution (or distinct part of an institution) that meets all of the following criteria:

1. Is primarily engaged in providing 24-hour-per-day accommodations and skilled nursing care inpatients recovering from illness or injury;
2. Is under the full-time supervision of a physician or registered nurse;
3. Admits patients only upon the recommendation of a physician, maintains adequate medical records for all patients, at all times has available the services of a physician under an established agreement;
4. Has established methods and written procedures for the dispensing and administration of drugs;
5. Is not, other than incidentally, a place for rest, a place for the aged, a place for substance abuse treatment; and
6. Is licensed in accordance with all applicable federal, state and local laws, and is approved by Medicare.

FOOT ORTHOTICS shall mean devices for support of the feet.

FORMER ELECTED OFFICIAL see ELIGIBLE FORMER ELECTED OFFICIAL

FRAUD shall mean an intentional deception or misrepresentation made by a Member or Dependent with the knowledge that the deception could result in some benefit to him/her or any other individual that would not otherwise be received. This includes any act that constitutes fraud under applicable federal or state law.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as presently enacted and as it may be amended in the future. It is a federal law intended to improve the availability and continuity of health insurance coverage.

HOMEBOUND shall be defined by Medicare as stated in Chapter 15 section 60.4.1 of the Medicare Benefit Policy Manual http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf.

HOME HEALTH CARE AGENCY shall mean a public agency or private organization or subdivision of an agency or organization that meets all of the following criteria:

1. Is primarily engaged in providing skilled nursing services and other therapeutic services such as physical therapy, speech therapy, occupational therapy, medical social services, or at-home health aide services. A public or voluntary non-profit health agency may qualify by furnishing directly either skilled nursing services or at least one other therapeutic service and by furnishing directly or indirectly (through arrangements with another public or voluntary non-profit agency) other therapeutic services;

2. Has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered nurse) to govern the services and provides for supervision of the services by a physician or a registered nurse;
3. Maintains complete clinical records on each patient;
4. Is licensed in accordance with federal, state and/or local laws; and
5. Meets all conditions of a home health care agency as required by Medicare.

HOSPICE FACILITY shall mean a facility other than a hospital which meets all of the following criteria:

1. Is primarily engaged in providing continuous skilled nursing care for terminally ill patients during the final stages of their illness and is not, other than incidentally, a rest home, home for custodial care, or home for the aged;
2. Regularly provides overnight care for patients in a residence or facility;
3. Provides 24-hour-per-day skilled nursing care by licensed nursing personnel under the direction of a full-time registered professional nurse; and
4. Maintains a complete medical record for each patient.

HOSPICE SERVICE shall mean an organization which is recognized by Medicare or which meets the following criteria:

1. Provides in-home nursing care and counseling by licensed professionals under the direction of a full-time registered professional nurse;
2. Maintains a complete medical record for each patient; and
3. Is primarily engaged in providing nursing care and counseling for terminally ill patients during the final stages of their illnesses and does not, other than incidentally, perform housekeeping duties.

HOSPITAL shall mean a licensed facility which provides inpatient diagnostic, therapeutic, and rehabilitative services for the diagnosis, treatment and care of injured and sick persons under the supervision of a physician. Such an institution must also meet the following requirements:

1. Is accredited by the Joint Commission of Hospitals, or approved by the federal government to participate in federal and state programs;
2. Maintains a complete medical record for each patient;
3. Has by-laws which govern its staff of physicians; and
4. Provides nursing care 24 hours per day.

HOSPITAL CONFINEMENT shall refer to a situation in which:

1. A room and board charge is made by a hospital or other facility approved by the Third Party Claim Administrator, or

2. A participant remains in the hospital or other approved facility for 24 consecutive hours or longer.

ILLNESS shall mean physical disease or sickness, including pregnancy.

IMMEDIATE RELATIVE shall mean a Spouse, parent, grandparent, child, grandchild, brother or sister of a participant, and any Dependent's family members.

IN-NETWORK shall mean utilization of services within the network of contracted providers associated with the Third Party Claim Administrator.

INJURY shall mean physical harm, including all related conditions and recurrent symptoms received by an individual as the result of any one (1) Accident.

INPATIENT shall mean the classification of a participant who is admitted to a hospital, hospice facility or extended care facility/skilled nursing facility for treatment, and room-and-board charges are made as a result of such treatment.

INTENSIVE CARE UNIT shall mean an area in a hospital, established by said hospital as a formal intensive care program exclusively reserved for critically ill patients requiring constant audiovisual observation as prescribed by the attending physician, that provides room and board, specialized, registered, professional nursing and other nursing care, and special equipment and supplies immediately available on a stand-by basis, and that is separated from the rest of the hospital's facilities.

LICENSED PRACTICAL NURSE shall mean an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

MEDICAID shall mean a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

MEDICAL EMERGENCY shall mean a sudden unexpected onset of bodily injury or serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention.

MEDICAL EXPENSE shall mean the reasonable and customary charges or the contracted fee as determined by the provider's network contract for services incurred by the participant for Medically Necessary services, treatments, supplies or drugs. Medical expenses are incurred as

of the date of the performance of the service or treatment, or the date of purchase of the supply or drug giving rise to the charge.

MEDICALLY NECESSARY/MEDICAL NECESSITY shall describe services, supplies and prescriptions, meeting all of the following criteria:

1. Ordered by a physician;
2. Not more extensive than required to meet the basic health needs;
3. Consistent with the diagnosis of the condition for which they are being utilized;
4. Consistent in type, frequency and duration of treatment with scientifically based guidelines by the medical-scientific community in the United States of America;
5. Required for purposes other than the comfort and convenience of the patient or provider;
6. Rendered in the least intensive setting that is appropriate for their delivery; and
7. Have demonstrated medical value.

MEDICARE shall mean the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

MEMBER shall mean an Eligible Employee, Eligible Retiree, or Eligible Former Elected Official that pays/contributes to the monthly premium required for enrollment in the Plan. Surviving Dependents and Surviving Children are considered Members in certain circumstances.

MENTAL or EMOTIONAL DISORDER shall mean a condition falling within categories 290 through 302 and 305 through 319 of the International Classification of Disease of the U.S. Department of Health, Education and Welfare (Health and Human Services), as amended.

MENTAL HEALTH shall mean the emotional well-being of an individual. Refer to the exclusions in the mental health section for specific information regarding any diagnosis that is not covered.

MULTIPLE SURGICAL PROCEDURES shall mean surgical procedures which are performed during the same operative session and which are not incidental or secondary to one primary procedure for which the operative session is undertaken. An "incidental procedure" is a procedure that is considered an integral part of another procedure and does not warrant a separate allowance. A "secondary procedure" is a procedure which is not part of the primary procedure for which the operative session is undertaken.

NATIONAL MEDICAL SUPPORT NOTICE shall mean the standardized federal form used by all state child support agencies to inform an employer that an Employee is obligated by court or administrative child support order to provide health care coverage for the Child(ren) identified on the notice. The employer is required to withhold any Employee contributions required by the health plan in which the Child(ren) is/are enrolled.

NETWORK PROVIDER/PARTICIPATING PROVIDER shall mean the group of health providers contracted for the purposes of providing services at a discounted rate. The network vendors provide access to these services through their contracted providers. The network vendors do not pay or process claims nor do they assume any liability for the funding of the claims or the Plan provisions. The State of Arizona has assumed all liability for claims payments based on the provisions and limitations stated in the Plan Document.

NETWORK shall mean the group of providers that are contracted with the networks associated with the Medical Vendor for the purpose of performing healthcare services at predetermined rates and with predetermined performance standards.

NON-OCCUPATIONAL ILLNESS or INJURY shall mean an illness or injury that does not arise out of and in the course of any employment for wage or profit; an illness for which the participant is not entitled to benefits under any workers' compensation law or similar legislation.

OPEN ENROLLMENT PERIOD shall mean the period of time established by the Plan sponsor when Members may enroll in the Plan or may modify their current coverage choices. When an Open Enrollment period is designated as "positive," all Members must complete the enrollment process.

OTHER PARTICIPATING HEALTH CARE FACILITY shall mean any facility other than a participating hospital or hospice facility that is operated by or has an agreement with the network(s) to render services to the participant. Examples include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

OTHER PARTICIPATING HEALTH PROFESSIONAL shall mean an individual other than a physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and who is contracted to provide services to the participant. Examples include, but are not limited to physical therapists, home health aides and nurses.

OUTPATIENT shall mean the classification of a participant receiving medical care other than as an inpatient.

OUT-OF-NETWORK shall mean the utilization of services outside of the network of contracted providers.

OUT-OF-POCKET EXPENSE shall mean a portion of the covered expense for which the participant is financially responsible. A copayment is not considered an out-of-pocket expense until the deductible is met.

OUT-OF-POCKET MAXIMUM shall mean the most any participant will pay in annual out-of-pocket expenses. Copayments do not accumulate toward the out-of-pocket maximum until the deductible is met. All charges associated with a non-covered service and all charges in excess of

Reasonable and Customary do not apply toward the accumulation of the out-of-pocket maximum.

PARTICIPANT shall mean a Member or a Dependent.

PARTICIPATING PROVIDER/NETWORK PROVIDER see "Network Provider/Participating Provider.

PHARMACY shall mean any area, place of business, or department, where prescriptions are filled or where drugs, or compounds are sold, offered, displayed for sale, dispensed, or distributed to the public. A pharmacy must also meet all of the following requirements:

1. Licensed by the Board of Pharmacy;
2. Maintains records in accordance with federal and state regulations; and
3. Staffed with a licensed registered pharmacist.

PHYSICIAN shall mean a person duly licensed to practice medicine, to prescribe and administer drugs, or to perform surgery. This definition includes doctors of medicine, doctors of osteopathy, dentists, podiatrists, chiropractors, psychologists and psychiatrists provided that each, under his/her license, is permitted to perform services covered under this Plan and that this Plan does not exclude the services provided by such physician. This definition also includes any other physician as determined by the Medical Vendor to be qualified to render the services for which a claim has been filed. For the purposes of accidental dental treatment, the definition of a physician may include a dentist or oral surgeon.

PLAN referred to in this document shall mean a period of twelve (12) consecutive months. For active Employees, Retirees, long term disability (LTD) recipients, Former Elected Officials, Surviving Spouses of participating Retirees, and Employee's eligibility for normal retirement this period commences on January 1 and ending on December 31. Any and all provisions revised in the Plan Document will become effective January 1 unless specified otherwise.

PLAN SPONSOR shall mean Benefit Services Division of the Arizona Department of Administration.

PLAN DESCRIPTION shall mean this written description of the Benefits Options medical insurance program.

PLAN YEAR shall mean a period of 12 consecutive months, commencing January 1st and ending December 31st.

POTENTIAL MEMBER shall mean an individual who is not currently enrolled in the Plan but who meets the eligibility requirements.

PRE-CERTIFICATION/PRIOR AUTHORIZATION shall mean the prospective determination performed by the Medical Vendor to determine the Medical Necessity and appropriateness of a proposed treatment, including level of care and treatment setting.

PRESCRIPTION BENEFIT MANAGEMENT VENDOR shall mean the entity contracted by the Arizona Department of Administration to adjudicate pharmacy claims according to the provisions of the Plan document as set forth by the Plan Sponsor. The PBM vendor does not diagnose or treat medical conditions or prescribe medications.

PRESCRIPTION DRUG shall mean a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.
PREMIUM shall mean the amount paid for coverage under the Plan.

PRIVATE DUTY NURSING shall mean services that are provided in a patient's residence from a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), in accordance with a physician's care plan. Private duty nursing services are provided by a licensed home care agency that is prescribed on an intermittent basis.

PRIVATE ROOM ACCOMODATIONS shall mean a hospital room containing one bed.

PROVIDER shall mean a duly licensed person or facility that furnishes healthcare services or supplies pursuant to law, provided that each, under his/her license, is permitted to furnish those services.

PSYCHIATRIC SERVICE shall mean psychotherapy and other accepted forms of evaluation, diagnosis, or treatment of mental or emotional disorders. This includes individual, group and family psychotherapy; electroshock and other convulsive therapy; psychological testing; psychiatric consultations; and any other forms of psychotherapeutic treatment as determined to be Medically Necessary by the Medical Vendor.

PSYCHOTHERAPIST shall mean a person licensed by the State of Arizona, degreed in counseling or otherwise certified as competent to perform psychotherapeutic counseling. This includes, but is not limited to: a psychiatrist, a psychologist, a pastoral counselor, a person degreed in counseling psychology, a psychiatric nurse, and a social worker, when rendering psychotherapy under the direct supervision of a psychiatrist or licensed psychotherapist.

QUALIFIED LIFE EVENT shall mean a change in a Member's or Dependent's eligibility, employment status, place of residence, Medicare-eligibility, or coverage options that triggers a

31-day period[12] in which the Member is allowed to make specific changes to his/her enrollment options. This includes, but is not limited to:

1. Change marital status such as marriage, divorce, legal separation, annulment, or death of Spouse;
2. Change in Dependent status such as birth, adoption, placement for adoption, death, or Dependent eligibility due to age;
3. Change in employment status or work schedule that affect benefits eligibility;
4. Change in residence that impacts available Plan options;
5. Compliance with a qualified medical child support order or national medical support notice;
6. Change in Medicare-eligibility;
7. Change in cost of coverage;
8. Restriction, loss, or improvement in coverage; or
9. Coverage under another employer plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER shall mean a court order that provides health benefit coverage for the child of the noncustodial parent under that parent's group health plan.

REASONABLE AND CUSTOMARY CHARGE shall mean the average charge for a service rendered in a specific geographical region and taking into account the experience, education and skill level of the provider rendering that service.

REGISTERED NURSE shall mean a graduate-trained nurse who has been licensed by a state authority after qualifying for registration.

REHABILITATION FACILITY shall mean a facility that specializes in physical rehabilitation of injured or sick patients. Such an institution must also meet all of the following criteria:

1. Qualifies as an extended care facility under Medicare;
2. Maintains a complete medical record for each patient;
3. Was established and is licensed and operated in accordance with the rules of legally authorized agencies responsible for medical institutions;
4. Maintains on its premises all the facilities necessary to provide for physician-supervised medical treatment of illness or injury; and
5. Must provide nursing services 24 hours per day by registered nurses or licensed practical nurses.

RELIABLE EVIDENCE shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the

[12] Pursuant to the Children's Health Insurance Program (CHIP) Reauthorization Act, individuals who lose Medicaid or CHIP coverage due to ineligibility have 60 days to request enrollment.

protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure.

RETIREE see ELIGIBLE RETIREE.

SEASONAL EMPLOYEE shall mean an individual who is employed by the state for not more than six months of the year and whose employment is dependent on an easily identifiable increase in work associated with a specific and reoccurring season. Seasonal Employees do not include employees of educational organizations who work during the active portions of the academic year.

SECTION 125 REGULATIONS OF THE INTERNAL REVENUE CODE or CAFETERIA PLAN shall mean a plan by which an employer can offer employees a choice between taxable and nontaxable benefits without the choice causing the benefits to become taxable. A Cafeteria Plan allows employees to pay for health insurance premiums and flexible spending account funds, on a pre-tax basis, thereby reducing their total taxable income.

SEMIPRIVATE ROOM ACCOMMODATION shall mean lodging in a hospital room that contains two, three, or four beds.

SERVICE AREA shall mean the nationwide network offered by the Third Party Claim Administrator.

SKILLED NURSING and SKILLED REHABILITATION SERVICES (OUTPATIENT) shall mean those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists and speech pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the individual and to achieve the medically desired result; and
- Are not custodial in nature.

SPECIALIZED HOSPITAL shall mean a facility specializing in the treatment of a specific disease or condition. This includes, but is not limited to, hospitals specializing in the treatment of mental or emotional disorders, alcoholism, drug dependence, or tuberculosis.

SPOUSE shall mean the Member's legal husband or wife.

SUBROGATION shall mean the procedure used by the Plan for the purpose of obtaining reimbursement for any payments made for medical services, prescriptions and supplies rendered to a participant as a result of damages, illness or injury inflicted by a third party.

SUBSTANCE ABUSE shall mean:

Alcoholism – A condition that falls within category 303 of the International Classification of Diseases of the U.S. Department of Health, Education and Welfare (Health and Human Services), as amended.

Drug Dependence (Chemical Dependence) – A condition that falls within category 304 of the International Classification of Diseases of the U.S. Department of Health, Education and Welfare (Health and Human Services), as amended.

Refer to the exclusions for specific codes in these diagnoses ranges that are not covered.

SURGICAL PROCEDURE shall mean one or more of the following types of medical procedures performed by a physician:

1. The incision, excision, or electro cauterization of any part of the body;
2. The manipulative reduction or treatment of a fracture or dislocation, including the application of a cast or traction;
3. The suturing of a wound;
4. Diagnostic and therapeutic endoscopic procedures; or
5. Surgical injection treatments or aspirations.

SURVIVING CHILD shall mean the Child who survives upon the death of his/her insured parent.

SURVIVING DEPENDENT shall mean the Spouse/Child who survives upon the death of the Member.

SURVIVING SPOUSE shall mean the legal husband or wife of a current or Former Elected Official, Employee, or Retiree, who survives upon the death of his/her Spouse.

TEMPORARY EMPLOYEE shall mean an appointment made for a maximum of 1,500 hours worked in any agency in each calendar year. A temporary appointment employee may work full time for a portion of the year, intermittently, on a seasonal basis, or on an as needed basis.

TERMINALLY ILL shall mean having a life expectancy of six months or less as certified in writing by the attending physician.

TIMELY FILING shall mean within one year after the date a service is rendered.

URGENT CARE FACILITY shall mean a facility other than a free clinic providing medical care and treatment of sick or injured persons on an outpatient basis. In addition, it must meet all of the following tests:

1. Is accredited by the Joint Commission on Accreditation of Hospitals, or be approved by the federal government to participate in federal and state programs;
2. Maintains on-premise diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified physicians;
3. Is operated continuously with organized facilities for minor operative surgery on the premises;
4. Has continuous physician services and registered professional nursing services whenever a patient visits the facility; and
5. Does not provide services or other accommodations for patients to stay overnight.

VARIABLE HOUR EMPLOYEE shall mean an individual employed by the state, if based on the facts and circumstances at the Employee's start date, for whom the state cannot determine whether the Employee is reasonably expected to be employed an average of at least 30 hours per week, including any paid leave, over the applicable 12-month measurement period because the Employee's hours are variable or otherwise uncertain.

EXHIBIT B

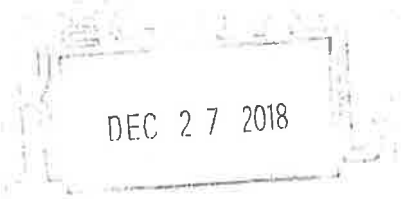
U.S. Department of Justice
Civil Rights Division
NOTICE OF RIGHT TO SUE WITHIN 90 DAYS

950 Pennsylvania Avenue, N.W.
Karen Ferguson , EMP, PHB, Room 4701
Washington, DC 20530

CERTIFIED MAIL
7003 0500 0002 5072 0599

December 14, 2018

Mr. Russell Toomey, PhD
c/o James Burr Shields, Esquire
Law Offices of Aiken & Schenk
2390 E. Camelback Rd.
Suite 400
Phoenix, AZ 85016



Re: EEOC Charge Against Board of Regents of the University of Arizona
No. 540201804629

Dear Mr. Toomey, PhD:

Because you filed the above charge with the Equal Employment Opportunity Commission, and the Commission has determined that it will not be able to investigate and conciliate that charge within 180 days of the date the Commission assumed jurisdiction over the charge and the Department has determined that it will not file any lawsuit(s) based thereon within that time, and because you through your attorney have specifically requested this Notice, you are hereby notified that you have the right to institute a civil action under Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000e, et seq., against the above-named respondent.

If you choose to commence a civil action, such suit must be filed in the appropriate Court within 90 days of your receipt of this Notice.

The investigative file pertaining to your case is located in the EEOC Phoenix District Office, Phoenix, AZ.

This Notice should not be taken to mean that the Department of Justice has made a judgment as to whether or not your case is meritorious.

Sincerely,

Eric S. Dreiband
Assistant Attorney General
Civil Rights Division

by Karen L. Ferguson
Karen L. Ferguson
Supervisory Civil Rights Analyst
Employment Litigation Section

cc: Phoenix District Office, EEOC
Board of Regents of the University of Arizona

EXHIBIT C

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(https://www.aetna.com/)

Gender Reassignment Surgery

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Number: 0615

Policy

Aetna considers gender reassignment surgery medically necessary when all of the following criteria are met:

I. Requirements for mastectomy for female-to-male patients:

A. Single letter of referral from a qualified mental health professional (see Appendix); *and*
B. Persistent, well-documented gender dysphoria (see Appendix); *and*
C. Capacity to make a fully informed decision and to consent for treatment; *and*
D. For members below the age of majority (less than 18 years of age), completion of one year of testosterone treatment; *and*
E. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy in adults.

II. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):

Policy History

Last Review

09/09/2019

Effective: 05/14/2002

Next Review: 06/26/2020

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes

A. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); *and*
B. Persistent, well-documented gender dysphoria (see Appendix); *and*
C. Capacity to make a fully informed decision and to consent for treatment; *and*
D. Age of majority (18 years or older); *and*
E. If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)

III. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female)

A. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); *and*
B. Persistent, well-documented gender dysphoria (see Appendix); *and*
C. Capacity to make a fully informed decision and to consent for treatment; *and*
D. Age of majority (age 18 years and older); *and*
E. If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); *and*
G. Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

Note: Blepharoplasty, body contouring (liposuction of the waist), breast enlargement procedures such as augmentation mammoplasty and implants, face-lifting, facial bone reduction, feminization of torso, hair removal, lip enhancement, reduction thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization, are considered cosmetic. Similarly, chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization, are considered cosmetic.

Note on gender specific services for the transgender community

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male trans identified persons who have not undergone a mastectomy;
2. Prostate cancer screening may be medically necessary for male to female trans identified persons who have retained their prostate.

Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria (see CPB 0501 - Gonadotropin-Releasing Hormone Analogs and Antagonists (../500_599/0501.html)).

Aetna considers the following procedures that may be performed as a component of a gender reassignment as cosmetic (not an all-inclusive list) (see also CPB 0031 - Cosmetic Surgery (../1_99/0031.html)):

- Abdominoplasty
- Blepharoplasty
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Construction of a clitoral hood
- Drugs for hair loss or growth
- Facial feminization and masculinization surgery
- Forehead lift
- Jaw reduction (jaw contouring)
- Hair removal (e.g., electrolysis, laser hair removal)
- Hair transplantation
- Lip reduction
- Liposuction

- Mastopexy
- Neck tightening
- Nipple reconstruction
- Nose implants
- Pectoral implants
- Pitch-raising surgery
- Removal of redundant skin
- Rhinoplasty
- Tracheal shave
- Voice therapy/voice lessons.

Background

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between an individual's gender identity and the gender assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). A diagnosis of gender dysphoria requires a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. This condition may cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender reassignment surgery is performed to change primary and/or secondary sex characteristics. For male to female gender reassignment, surgical procedures may include genital reconstruction (vaginoplasty, penectomy, orchidectomy, clitoroplasty) and cosmetic surgery (breast implants, facial reshaping, rhinoplasty, abdominoplasty, thyroid chondroplasty (laryngeal shaving), voice modification surgery (vocal cord shortening), hair transplants) (Day, 2002). For female to male gender reassignment, surgical procedures may include mastectomy, genital reconstruction (phalloplasty, genitoplasty, hysterectomy, bilateral oophorectomy), mastectomy, and cosmetic procedures to enhance male features such as pectoral implants and chest wall recontouring (Day, 2002).

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery (Coleman, et al., 2011).

In addition to hormone therapy and gender reassignment surgery, psychological adjustments are necessary in affirming sex. Treatment should focus on psychological adjustment, with hormone therapy and gender reassignment surgery being viewed as confirmatory procedures dependent on adequate psychological adjustment. Mental health care may need to be continued after gender reassignment surgery. The overall success of treatment depends partly on the technical success of the surgery, but more crucially on the psychological adjustment of the trans identified person and the support from family, friends, employers and the medical profession.

Nakatsuka (2012) noted that the 3rd versions of the guideline for treatment of people with gender dysphoria (GD) of the Japanese Society of Psychiatry and Neurology recommends that feminizing/masculinizing hormone therapy and genital surgery should not be carried out until 18 years old and 20 years old, respectively. On the other hand, the 6th (2001) and the 7th (2011) versions of the standards of care for the health of transsexual, transgender, and gender non-conforming people of World Professional Association for Transgender Health (WPATH) recommend that transgender adolescents (Tanner stage 2, [mainly 12 to 13 years of age]) are treated by the endocrinologists to suppress puberty with gonadotropin-releasing hormone (GnRH) agonists until age 16 years old, after which cross-sex hormones may be given. A questionnaire on 181 people with GID diagnosed in the Okayama University Hospital (Japan) showed that female to male (FTM) trans identified individuals hoped to begin masculinizing hormone therapy at age of 15.6 +/- 4.0 (mean +/- S.D.) whereas male to female (MTF) trans identified individuals hoped to begin feminizing hormone therapy as early as age 12.5 +/- 4.0, before presenting secondary sex characters. After confirmation of strong and persistent trans gender identification, adolescents with GD should be treated with cross-gender hormone or puberty-delaying hormone to prevent developing undesired sex characters. These treatments may prevent transgender adolescents from attempting suicide, suffering from depression, and refusing to attend school.

Spack (2013) stated that GD is poorly understood from both mechanistic and clinical standpoints. Awareness of the condition appears to be increasing, probably because of greater societal acceptance and available hormonal treatment. Therapeutic options include hormone and surgical treatments but may be limited by insurance coverage because costs are high. For patients seeking MTF affirmation, hormone treatment includes estrogens, finasteride, spironolactone, and GnRH analogs. Surgical options include feminizing genital and facial surgery, breast augmentation, and various fat transplantations. For patients seeking a FTM gender affirmation, medical therapy includes testosterone and GnRH analogs and surgical

therapy includes mammoplasty and phalloplasty. Medical therapy for both FTM and MTF can be started in early puberty, although long-term effects are not known. All patients considering treatment need counseling and medical monitoring.

Leinung and colleagues (2013) noted that the Endocrine Society's recently published clinical practice guidelines for the treatment of transgender persons acknowledged the need for further information on transgender health. These investigators reported the experience of one provider with the endocrine treatment of transgender persons over the past 2 decades. Data on demographics, clinical response to treatment, and psychosocial status were collected on all transgender persons receiving cross-sex hormone therapy since 1991 at the endocrinology clinic at Albany Medical Center, a tertiary care referral center serving upstate New York. Through 2009, a total 192 MTF and 50 FTM transgender persons were seen. These patients had a high prevalence of mental health and psychiatric problems (over 50 %), with low rates of employment and high levels of disability. Mental health and psychiatric problems were inversely correlated with age at presentation. The prevalence of gender reassignment surgery was low (31 % for MTF). The number of persons seeking treatment has increased substantially in recent years. Cross-sex hormone therapy achieves very good results in FTM persons and is most successful in MTF persons when initiated at younger ages. The authors concluded that transgender persons seeking hormonal therapy are being seen with increasing frequency. The dysphoria present in many transgender persons is associated with significant mood disorders that interfere with successful careers. They stated that starting therapy at an earlier age may lessen the negative impact on mental health and lead to improved social outcomes.

Meyer-Bahlburg (2013) summarized for the practicing endocrinologist the current literature on the psychobiology of the development of gender identity and its variants in individuals with disorders of sex development or with transgenderism. Gender reassignment remains the treatment of choice for strong and persistent gender dysphoria in both categories, but more research is needed on the short-term and long-term effects of puberty-suppressing medications and cross-sex hormones on brain and behavior.

Irreversible Surgical Interventions for Minors

The World Professional Association for Transgender Health (WPATH) recommendations version 7 (Coleman, et al., 2011) states, regarding irreversible surgical interventions, that " [g]enital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention." The WPATH guidelines

state that "Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression."

Note on Nipple Reconstruction

Aetna considers nipple reconstruction, as defined by the American Medical Association (AMA) Current Procedural Terminology (CPT) code 19350, cosmetic/not medically necessary for mastectomy for female to male gender reassignment. Performance of a mastectomy for gender reassignment does not involve a nipple reconstruction as defined by CPT code 19350.

Some have cited breast reconstruction surgery for breast cancer, i.e., recreation of a breast after mastectomy, as support for coverage of nipple reconstruction. Mastectomy for female to male gender reassignment surgery, however, involves mastectomy without restoration of the breast. There are important differences between a mastectomy for breast cancer and a mastectomy for gender reassignment. The former requires careful attention to removal of all breast tissue to reduce the risk of cancer. By contrast, careful removal of all breast tissue is not essential in mastectomy for gender reassignment.

In mastectomy for gender reassignment, the nipple areola complex typically can be preserved. There is no routine indication for nipple reconstruction as defined by CPT code 19350, the exceptions being unusual cases where construction of a new nipple may be necessary in persons with very large and ptotic breasts. See, e.g., Bowman, et al., 2006).

Some have justified routinely billing CPT code 19350 for nipple reconstruction code for mastectomy for gender reassignment based upon the frequent need to reduce the size of the areola to give it a male appearance. However, the nipple reconstruction as defined by CPT code 19350 describes a much more involved procedure than areola reduction. The typical patient vignette for CPT code 19350, according to the AMA, is as follows: "The patient is measured in the standing position to ensure even balanced position for a location of the nipple and areola graft on the right breast. Under local anesthesia, a Skate flap is elevated at the site selected for the nipple reconstruction and constructed. A full-thickness skin graft is taken from the right groin to reconstruct the areola. The right groin donor site is closed primarily in layers."

Aetna will consider allowing modifier -22 to be appended to the mastectomy CPT code when this procedure is performed for gender reassignment to allow additional reimbursement for the extra work that may be necessary to reshape the nipple and create an aesthetically pleasing male chest. CPT code 19350 does not describe the work that that is being done, because that code describes the actual construction of a new nipple. The CPT defines modifier 22 as "Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)."

Thus, Aetna considers nipple reconstruction, as defined by CPT code 19350, as cosmetic/not medically necessary for mastectomy for female to male gender reassignment, and that appending modifier 22 to the mastectomy code would more accurately reflect the extra work that may typically be necessary to obtain an aesthetically pleasing result.

Vulvoplasty versus Vaginoplasty as Gender-Affirming Genital Surgery for Transgender Women

Jiang and colleagues (2018) noted that gender-affirming vaginoplasty aims to create the external female genitalia (vulva) as well as the internal vaginal canal; however, not all patients desire nor can safely undergo vaginal canal creation. These investigators described the factors influencing patient choice or surgeon recommendation of vulvoplasty (creation of the external appearance of female genitalia without creation of a neovaginal canal) and evaluated the patient's satisfaction with this choice. Gender-affirming genital surgery consults were reviewed from March 2015 until December 2017, and patients scheduled for or who had completed vulvoplasty were interviewed by telephone. These investigators reported demographic data and the reasons for choosing vulvoplasty as gender-affirming surgery for patients who either completed or were scheduled for surgery, in addition to patient reports of satisfaction with choice of surgery, satisfaction with the surgery itself, and sexual activity after surgery. A total of 486 patients were seen in consultation for trans-feminine gender-affirming genital surgery: 396 requested vaginoplasty and 39 patients requested vulvoplasty; 30 Patients either completed or are scheduled for vulvoplasty. Vulvoplasty patients were older and had higher body mass index (BMI) than those seeking vaginoplasty. The majority (63 %) of the patients seeking vulvoplasty chose this surgery despite no contraindications to vaginoplasty. The remaining patients had risk factors leading the surgeon to recommend vulvoplasty. Of those who completed surgery, 93 % were satisfied with the surgery and their decision for vulvoplasty. The authors concluded

that this was the first study of factors impacting a patient's choice of or a surgeon's recommendation for vulvoplasty over vaginoplasty as gender-affirming genital surgery; it also was the first reported series of patients undergoing vulvoplasty only.

Drawbacks of this study included its retrospective nature, non-validated questions, short-term follow-up, and selection bias in how vulvoplasty was offered. Vulvoplasty is a form of gender-affirming feminizing surgery that does not involve creation of a neovagina, and it is associated with high satisfaction and low decision regret.

Autologous Fibroblast-Seeded Amnion for Reconstruction of Neo-vagina in Male-to-Female Reassignment Surgery

Seyed-Forootan and colleagues (2018) stated that plastic surgeons have used several methods for the construction of neo-vaginas, including the utilization of penile skin, free skin grafts, small bowel or recto-sigmoid grafts, an amnion graft, and cultured cells. These researchers compared the results of amnion grafts with amnion seeded with autograft fibroblasts. Over 8 years, these investigators compared the results of 24 male-to-female transsexual patients retrospectively based on their complications and levels of satisfaction; 16 patients in group A received amnion grafts with fibroblasts, and the patients in group B received only amnion grafts without any additional cellular lining. The depths, sizes, secretions, and sensations of the vaginas were evaluated. The patients were monitored for any complications, including over-secretion, stenosis, stricture, fistula formation, infection, and bleeding. The mean age of group A was 28 ± 4 years and group B was 32 ± 3 years. Patients were followed-up from 30 months to 8 years (mean of 36 ± 4) after surgery. The depth of the vaginas for group A was 14 to 16 and 13 to 16 cm for group B. There was no stenosis in neither group. The diameter of the vaginal opening was 34 to 38 mm in group A and 33 to 38 cm in group B. These researchers only had 2 cases of stricture in the neo-vagina in group B, but no stricture was recorded for group A. All of the patients had good and acceptable sensation in the neo-vagina; 75 % of patients had sexual experience and of those, 93.7 % in group A and 87.5% in group B expressed satisfaction. The authors concluded that the creation of a neo-vaginal canal and its lining with allograft amnion and seeded autologous fibroblasts is an effective method for imitating a normal vagina. The size of neo-vagina, secretion, sensation, and orgasm was good and proper. More than 93.7 % of patients had satisfaction with sexual intercourse. They stated that amnion seeded with fibroblasts extracted from the patient's own cells will result in a vagina with the proper size and moisture that can eliminate the need for long-term dilatation. The constructed vagina has a 2-layer structure and is much more resistant to trauma and laceration. No cases of stenosis or stricture were recorded. Level of Evidence = IV. These preliminary findings need to be validated by well-designed studies.

Pitch-Raising Surgery in Male-to-Female Transsexuals

Van Damme and colleagues (2017) reviewed the evidence of the effectiveness of pitch-raising surgery performed in male-to-female transsexuals. These investigators carried out a search for studies in PubMed, Web of Science, Science Direct, EBSCOhost, Google Scholar, and the references in retrieved manuscripts, using as keywords "transsexual" or "transgender" combined with terms related to voice surgery. They included 8 studies using cricothyroid approximation, 6 studies using anterior glottal web formation, and 6 studies using other surgery types or a combination of surgical techniques, leading to 20 studies in total. Objectively, a substantial rise in post-operative fundamental frequency was identified. Perceptually, mainly laryngeal web formation appeared risky for decreasing voice quality. The majority of patients appeared satisfied with the outcome. However, none of the studies used a control group and randomization process. The authors concluded that future research needs to investigate long-term effects of pitch-raising surgery using a stronger study design.

Azul and associates (2017) evaluated the currently available discursive and empirical data relating to those aspects of trans-masculine people's vocal situations that are not primarily gender-related, and identified restrictions to voice function that have been observed in this population, and made suggestions for future voice research and clinical practice. These researchers conducted a comprehensive review of the voice literature. Publications were identified by searching 6 electronic databases and bibliographies of relevant articles. A total of 22 publications met inclusion criteria. Discourses and empirical data were analyzed for factors and practices that impact on voice function and for indications of voice function-related problems in trans-masculine people. The quality of the evidence was appraised. The extent and quality of studies investigating trans-masculine people's voice function was found to be limited. There was mixed evidence to suggest that trans-masculine people might experience restrictions to a range of domains of voice function, including vocal power, vocal control/stability, glottal function, pitch range/variability, vocal endurance, and voice quality. The authors concluded that more research into the different factors and practices affecting trans-masculine people's voice function that took account of a range of parameters of voice function and considered participants' self-evaluations is needed to establish how functional voice production can be best supported in this population.

Facial Feminization Surgery

Raffaini and colleagues (2016) stated that gender dysphoria refers to the discomfort and distress that arise from a discrepancy between a person's gender identity and sex assigned at birth. The treatment plan for gender dysphoria varies and can include psychotherapy, hormone

treatment, and gender reassignment surgery, which is, in part, an irreversible change of sexual identity. Procedures for transformation to the female sex include facial feminization surgery, vaginoplasty, clitoroplasty, and breast augmentation. Facial feminization surgery can include forehead re-modeling, rhinoplasty, mentoplasty, thyroid chondroplasty, and voice alteration procedures. These investigators reported patient satisfaction following facial feminization surgery, including outcome measurements after forehead slippage and chin re-modeling. A total of 33 patients between 19 and 40 years of age were referred for facial feminization surgery between January of 2003 and December of 2013, for a total of 180 procedures. Surgical outcome was analyzed both subjectively through questionnaires administered to patients and objectively by serial photographs. Most facial feminization surgery procedures could be safely completed in 6 months, barring complications. All patients showed excellent cosmetic results and were satisfied with their procedures. Both frontal and profile views achieved a loss of masculine features. The authors concluded that patient satisfaction following facial feminization surgery was high; they stated that the reduction of gender dysphoria had psychological and social benefits and significantly affected patient outcome. Leve of Evidence = IV.

Morrison and associates (2018) noted that facial feminization surgery encompasses a broad range of cranio-maxillofacial surgical procedures designed to change masculine facial features into feminine features. The surgical principles of facial feminization surgery could be applied to male-to-female transsexuals and anyone desiring feminization of the face. Although the prevalence of these procedures is difficult to quantify, because of the rising prevalence of transgenderism (approximately 1 in 14,000 men) along with improved insurance coverage for gender-confirming surgery, surgeons versed in techniques, outcomes, and challenges of facial feminization surgery are needed. These researchers appraised the current facial feminization surgery literature. They carried out a comprehensive literature search of the Medline, PubMed, and Embase databases was conducted for studies published through October 2014 with multiple search terms related to facial feminization. Data on techniques, outcomes, complications, and patient satisfaction were collected. A total of 15 articles were selected and reviewed from the 24 identified, all of which were either retrospective or case series/reports. Articles covered a variety of facial feminization procedures. A total of 1,121 patients underwent facial feminization surgery, with 7 complications reported, although many articles did not explicitly comment on complications. Satisfaction was high, although most studies did not use validated or quantified approaches to address satisfaction. The authors concluded that facial feminization surgery appeared to be safe and satisfactory for patients. These researchers

stated that further studies are needed to better compare different techniques to more robustly establish best practices; prospective studies and patient-reported outcomes are needed to establish quality-of-life (QOL) outcomes for patients.

Appendix

DSM 5 Criteria for Gender Dysphoria in Adults and Adolescents

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following:

I. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
II. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
III. A strong desire for the primary and/or secondary sex characteristics of the other gender
IV. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
V. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
VI. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Format for referral letters from Qualified Health Professional: (From SOC-7)

I. Client's general identifying characteristics; *and*
II. Results of the client's psychosocial assessment, including any diagnoses; *and*
III. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date; *and*

IV. An explanation that the WPATH criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery; *and*
V. A statement about the fact that informed consent has been obtained from the patient; *and*
VI. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

Note: There is no minimum duration of relationship required with mental health professional. It is the professional's judgment as to the appropriate length of time before a referral letter can appropriately be written. A common period of time is three months, but there is significant variation in both directions. When two letters are required, the second referral is intended to be an evaluative consultation, not a representation of an ongoing long-term therapeutic relationship, and can be written by a medical practitioner of sufficient experience with gender dysphoria.

Note: Evaluation of candidacy for sex reassignment surgery by a mental health professional is covered under the member's medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the member's behavioral health benefit. Please check benefit plan descriptions.

Characteristics of a Qualified Mental Health Professional: (From SOC-7)

I. Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent; *and*
II. Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes; *and*
III. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; *and*
IV. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; *and*
V. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

Code	Code Description
CPT codes covered if selection criteria are met:	
19301, 19303 - 19304	Mastectomy
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400 - 54417	Penile prosthesis
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopic, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	complicated
55970	Intersex surgery; male to female [a series of staged procedures that includes male genitalia removal, penile dissection, urethral transposition, creation of vagina and labia with stent placement]
55980	female to male [a series of staged procedures that include penis and scrotum formation by graft, and prostheses placement]
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106 - 57107, 57110 - 57111	Vaginectomy
57291 - 57292	Construction of artificial vagina
57335	Vaginoplasty for intersex state

Code	Code Description
58150, 58180, 58260 - 58262, 58275 - 58291, 58541 - 58544, 58550 - 58554	Hysterectomy
58570 - 58573	Laparoscopy, surgical, with total hysterectomy
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral
CPT codes not covered for indications listed in the CPB [considered cosmetic]:	
Tracheal shave - no specific code:	
11950 - 11954	Subcutaneous injection of filling material (e.g., collagen)
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less [nipple reconstruction]
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780 - 15787	Dermabrasion
15788 - 15793	Chemical peel
15820 - 15823	Blepharoplasty
15824 - 15828	Rhytidectomy [face-lifting]
15830 - 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15876 - 15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19316	Mastopexy
19318	Reduction mammaplasty
19324 - 19325	Mammaplasty, augmentation
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

Code	Code Description
19350	Nipple/areola reconstruction
21087	Nasal prosthesis
21120 - 21123	Genioplasty
21125 - 21127	Augmentation, mandibular body or angle; prosthetic material or with bone graft, onlay or interpositional (includes obtaining autograft)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	with internal rigid fixation
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400 - 30420	Rhinoplasty; primary
30430 - 30450	Rhinoplasty; secondary
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals
Other CPT codes related to the CPB:	
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
+90785	Interactive complexity (List separately in addition to the code for primary procedure)
90832 - 90838	Psychotherapy
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance of drug); subcutaneous or intramuscular
HCPCS codes covered if selection criteria are met:	
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable

Code	Code Description
J1071	Injection, testosterone cypionate, 1 mg
J3121	Injection, testosterone enanthate, 1 mg
J3145	Injection, testosterone undecanoate, 1 mg
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J9202	Goserelin acetate implant, per 3.6 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg
J9219	Leuprolide acetate implant, 65 mg
S0189	Testosterone pellet, 75 mg
HCPCS codes not covered for indications listed in the CPB :	
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
S9128	Speech therapy, in the home, per diem
ICD-10 codes covered if selection criteria are met:	
F64.0 - F64.1	Transexualism and dual role transvestism
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment
ICD-10 codes not covered for indications listed in the CPB:	
F64.2	Gender identity disorder of childhood

The above policy is based on the following references:

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EXHIBIT D

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MEDICAL COVERAGE GUIDELINES
SECTION: MEDICINE

ORIGINAL EFFECTIVE DATE: 06/20/17
LAST REVIEW DATE: 09/04/18
LAST CRITERIA REVISION DATE: 08/21/18
ARCHIVE DATE:

TREATMENTS FOR GENDER DYSPHORIA

Non-Discrimination Statement and Multi-Language Interpreter Services information are located at the end of this document.

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Medical Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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MEDICAL COVERAGE GUIDELINES
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ORIGINAL EFFECTIVE DATE: 06/20/17
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ARCHIVE DATE:

TREATMENTS FOR GENDER DYSPHORIA (cont.)

Description:

Gender dysphoria refers to the discomfort or distress caused by discrepancy between an individual's gender identity and the gender assigned at birth.

1. Treatments for gender dysphoria include:
   - Medical treatment
   - Hormone therapy(routes of administration include buccal tablets, intramuscular injections, oral medication, topical gel and topical patches)
   - Psychotherapy

2. Surgical procedures to change primary and secondary sex characteristics (i.e., breast/chest, genitalia). Surgery, particularly genital surgery, is often the last and the most considered step in the treatment process for gender dysphoria.

Female-to-Male (FTM) Surgical Procedures

Breast/Chest Surgery	Genital Surgery
Subcutaneous mastectomy	Hysterectomy/salpingo-oophorectomy
Chest reconstruction in conjunction with bilateral mastectomy	Implantation of penile erection and/or testicular prostheses
	Metoidioplasty or phalloplasty
	Scrotoplasty
	Urethroplasty
	Vaginectomy

Male-to-Female (MTF) Surgical Procedures

Breast/Chest Surgery	Genital Surgery
Augmentation mammoplasty (implants/lipofilling)	Clitoroplasty
	Orchiectomy
	Penectomy
	Urethroplasty
	Vaginoplasty
	Vulvoplasty

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MEDICAL COVERAGE GUIDELINES
SECTION: MEDICINE

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LAST CRITERIA REVISION DATE: 08/21/18
ARCHIVE DATE:

TREATMENTS FOR GENDER DYSPHORIA (cont.)

Description: (cont.)

Referral for Surgery:
Surgical treatments for gender dysphoria are initiated by a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation, in the chart and/or referral letter, of the individual's personal and treatment history, progress and eligibility.

Breast surgery requires one referral from a qualified mental health professional.

Genital surgery requires two referrals from qualified mental health professionals. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of referral letters for surgery is as follows:

1. General identifying characteristics
2. Psychosocial assessment results, including diagnoses
3. Duration of the mental health professional's relationship with the individual, including the type of evaluation and therapy or counseling to date
4. Explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the surgery request
5. Statement that informed consent has been obtained from the individual seeking surgery
6. Statement that the mental health professional is available for coordination of care.

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MEDICAL COVERAGE GUIDELINES
SECTION: MEDICINE

ORIGINAL EFFECTIVE DATE: 06/20/17
LAST REVIEW DATE: 09/04/18
LAST CRITERIA REVISION DATE: 08/21/18
ARCHIVE DATE:

TREATMENTS FOR GENDER DYSPHORIA (cont.)

Definitions:

Cosmetic:
Surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including *but not limited to*, those surgeries, procedures, treatments and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological or mental condition.

Liposuction and lipofilling of the chest, waist, hips and buttocks are cosmetic contouring procedures to feminize or masculinize the body. FTM chest contouring produces a masculine V-shaped torso. MTF contouring produces feminine features such as a curvier waist and fuller hips and buttocks.

FTM facial masculinization procedures include *but are not limited to*: forehead lengthening and augmentation, chin, cheek and jaw augmentation, hair transplant, rhinoplasty/nasal augmentation and thyroid cartilage/Adam's Apple enhancement.

MTF facial feminization procedures include *but are not limited to*: brow lift, cheek implants/enhancement, chin and jaw contouring, forehead reduction/contouring, hairline advancement, lip augmentation, rhinoplasty and thyroid cartilage/Adam's Apple reduction.

Gender Reassignment Surgery:
Surgery to change primary and/or secondary sex characteristics to affirm an individual's gender identity. Sex or gender reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria. May also be known as gender or transgender transition surgery.

Hormone Therapy for Adolescents:
Endocrine Society Clinical Practice Guidelines for endocrine treatment of transsexual persons state that adolescents are eligible and ready for gonadotropin-releasing hormone (GnRH) therapy for suppression of puberty if they:

1. Fulfill DSM IV-TR or ICD-10 criteria for gender identity disorder (GID) or transsexualism
2. Have experienced puberty to at least Tanner stage 2
3. Have (early) pubertal changes that have resulted in an increase of their gender dysphoria
4. Do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment
5. Have adequate psychological and social support during treatment
6. Demonstrate knowledge and understanding of the expected outcomes of GnRH analog treatment, cross-sex hormone treatment, and sex reassignment surgery, as well as the medical and the social risks and benefits of sex reassignment

TREATMENTS FOR GENDER DYSPHORIA (cont.)

Definitions: (cont.)

Transgender:
Describes a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth.

Transition:
Transition is the period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition are variable and individualized.

Suppression of puberty using hormone therapy is not considered transition.

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SECTION: MEDICINE

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LAST CRITERIA REVISION DATE: 08/21/18
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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria:

COVERAGE FOR GENDER DYSPHORIA TREAMENT IS DEPENDENT UPON BENEFIT PLAN LANGUAGE. REFER TO MEMBER'S SPECIFIC BENEFIT PLAN BOOKLET TO VERIFY BENEFITS.

If benefit coverage for gender dysphoria treatment is available, requests for gender dysphoria treatment will be reviewed by the medical director(s) and/or clinical advisor(s).

Medical Treatment for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available**, the following medical treatments are considered ***medically necessary***:

  1. Female-to-male hormone therapy[1]
  2. Male-to-female hormone therapy[1]
  3. Psychotherapy

- **If benefit coverage for gender dysphoria treatment is available,** subcutaneous hormone pellet implants are considered ***experimental or investigational*** based upon:

  1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  2. Insufficient evidence to support improvement of the net health outcome, and
  3. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives.

  These indications include, *but are not limited to:*

  - Female-to-male hormone therapy
  - Male-to-female hormone therapy

- **If benefit coverage for gender dysphoria treatment is not available**, gender dysphoria medical treatment is considered ***a benefit plan exclusion*** and ***not eligible for coverage.***

[1] Includes buccal tablets, intramuscular injections, oral medication, topical gel and topical patches.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Female-to-Male:

Surgical Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** the following surgical procedures are considered ***eligible for coverage***:

1. Mastectomy with documentation of **ALL** of the following:

   - One referral from qualified mental health professional
   - Persistent, well-documented gender dysphoria
   - Capacity to make a fully informed decision and to give consent for treatment
   - Age of majority in a given country (if younger, follow the standards of care for children and adolescents)
   - If significant medical or mental health concerns are present, they must be reasonably well controlled

Hormone therapy is not a prerequisite.

2. Hysterectomy/salpingo-oophorectomy with documentation of **ALL** of the following:

   - Two referrals from qualified mental health professionals
   - Persistent, well documented gender dysphoria
   - Capacity to make a fully informed decision and to give consent for treatment
   - Age of majority in a given country
   - If significant medical or mental health concerns are present, they must be well controlled
   - 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless hormones are not clinically indicated for the individual)

These criteria do not apply to individuals having these surgical procedures for medical indications other than gender dysphoria.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Female-to-Male: (cont.)

Surgical Procedures for Gender Dysphoria: (cont.)

- **If benefit coverage for gender dysphoria treatment is available,** the following surgical procedures are considered ***eligible for coverage***: (cont.)

  3. Scrotoplasty, implantation of penile erection and/or testicular prostheses, metoidioplasty or phalloplasty, urethroplasty and vaginectomy with documentation of **ALL** of the following:

     - Two referrals from qualified mental health professionals
     - Persistent, well documented gender dysphoria
     - Capacity to make a fully informed decision and to consent for treatment
     - Age of majority in a given country
     - If significant medical or mental health concerns are present, they must be well controlled
     - 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless hormones are not clinically indicated for the individual)
     - 12 continuous months of living in a gender role that is congruent with their gender identity

Although not an explicit criterion, it is recommended that these individuals also have regular visits with a mental health or other medical professional.

- **If benefit coverage for gender dysphoria treatment is available,** all other surgical procedures are considered ***cosmetic, not eligible for coverage*** and ***not medically necessary***. See page 10 for list of procedures.

- **If benefit coverage for gender dysphoria treatment is not available,** surgical procedures for gender dysphoria are considered ***a benefit plan exclusion*** and ***not eligible for coverage***.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Female-to-Male: (cont.)

Other Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** preoperative permanent removal of genital hair with electrolysis prior to a metoidioplasty, phalloplasty, scrotoplasty and urethroplasty is considered ***eligible for coverage***.
- **If benefit coverage for gender dysphoria treatment is available,** postoperative permanent removal of genital hair with electrolysis following a metoidioplasty, phalloplasty, scrotoplasty and urethroplasty is considered ***eligible for coverage*** with documentation that postoperative genital hair is causing functional limitation or dysfunction.
- **If benefit coverage for gender dysphoria treatment is available,** permanent removal of genital hair with electrolysis for all other indications not previously listed or if above criteria not met is considered ***cosmetic, not eligible for coverage*** and ***not medically necessary***. See page 10 for list of other hair procedures.
- **If benefit coverage for gender dysphoria treatment is not available,** permanent removal of genital hair with electrolysis is considered ***a benefit plan exclusion*** and ***not eligible for coverage***.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Male-to-Female:

Surgical Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** the following surgical procedures are considered ***eligible for coverage***:

1. Initial breast augmentation (implants/lipofilling) with documentation of **ALL** of the following:

   - One referral from qualified mental health professional
   - Persistent, well-documented gender dysphoria
   - Capacity to make a fully informed decision and to give consent for treatment
   - Age of majority in a given country (if younger, follow the SOC for children and adolescents)
   - If significant medical or mental health concerns are present, they must be reasonably well controlled

Although not an explicit criterion, feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery is recommended. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

2. Orchiectomy and penectomy with documentation of **ALL** of the following:

   - Two referrals from qualified mental health professionals
   - Persistent, well documented gender dysphoria
   - Capacity to make a fully informed decision and to give consent for treatment
   - Age of majority in a given country
   - If significant medical or mental health concerns are present, they must be well controlled
   - 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless hormones are not clinically indicated for the individual)

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, prior to irreversible surgical intervention.

These criteria do not apply to individuals having these surgical procedures for medical indications other than gender dysphoria.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Male-to-Female: (cont.)

Surgical Procedures for Gender Dysphoria: (cont.)

- **If benefit coverage for gender dysphoria treatment is available,** the following surgical procedures are considered ***eligible for coverage***: (cont.)

  3. Clitoroplasty, urethroplasty, vaginoplasty and vulvoplasty with documentation of **ALL** of the following:

     - Two referrals from qualified mental health professionals
     - Persistent, well documented gender dysphoria
     - Capacity to make a fully informed decision and to consent for treatment
     - Age of majority in a given country
     - If significant medical or mental health concerns are present, they must be well controlled
     - 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless hormones are not clinically indicated for the individual)
     - 12 continuous months of living in a gender role that is congruent with their gender identity

Although not an explicit criterion, it is recommended that these individuals also have regular visits with a mental health or other medical professional.

- **If benefit coverage for gender dysphoria treatment is available,** all other surgical procedures are considered ***cosmetic, not eligible for coverage*** and ***not medically necessary***. See page 10 for list of procedures.

- **If benefit coverage for gender dysphoria treatment is not available,** surgical procedures for gender dysphoria are considered ***a benefit plan exclusion*** and ***not eligible for coverage***.

Other Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** preoperative permanent removal of genital hair with electrolysis prior to a clitoroplasty, penectomy, urethroplasty, vaginoplasty and vulvoplasty is considered ***eligible for coverage***.

- **If benefit coverage for gender dysphoria treatment is available,** postoperative permanent removal of genital hair with electrolysis following a clitoroplasty, penectomy, urethroplasty, vaginoplasty and is considered ***eligible for coverage*** with documentation that postoperative genital hair is causing functional limitation or dysfunction.

- **If benefit coverage for gender dysphoria treatment is not available,** permanent removal of genital hair with electrolysis is considered ***a benefit plan exclusion*** and ***not eligible for coverage***.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Cosmetic Surgical Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** the following procedures are considered ***cosmetic, not eligible for coverage*** and ***not medically necessary***.

  These procedures include, *but are not limited to:*

1. Abdominoplasty
2. Blepharoplasty
3. Brow lift
4. Calf implants
5. Cheek/malar implants/enhancement
6. Chest contouring (lipofilling, liposuction)
7. Chin/nose augmentation (implants) and contouring
8. Collagen injections
9. Face lift
10. Forehead lengthening, augmentation and reduction/contouring
11. Facial feminization/masculinization surgery
12. Gluteal augmentation (implants/lipofilling)
13. Hair transplantation
14. Hairline advancement
15. Jaw augmentation and shortening/sculpturing/facial bone reduction
16. Lip reduction and augmentation/enhancement
17. Lipofilling
18. Liposuction
19. Mastopexy
20. Neck tightening
21. Nipple/areola reconstruction
22. Pectoral implants
23. Permanent removal of genital hair with electrolysis for all other indications not previously listed or if above criteria not met
24. Removal of non-genital hair (electrolysis, laser)
25. Removal of redundant skin
26. Repeat female-to-male genital surgical procedures
27. Repeat male-to-female breast augmentation (implants/lipofilling) or revisions to initial breast augmentation (implants/lipofilling)
28. Replacement of tissue expander with permanent prosthesis testicular insertion
29. Rhinoplasty
30. Skin resurfacing (e.g., dermabrasion, chemical peels)
31. Thyroid cartilage augmentation/enhancement and reduction/trachea shave
32. Voice modification surgery/laryngoplasty
33. Voice therapy/voice lessons

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Fertility/Infertility Services for Gender Dysphoria:

COVERAGE FOR FERTILITY/INFERTILITY SERVICES FOR GENDER DYSPHORIC MEMBERS IS DEPENDENT UPON BENEFIT PLAN LANGUAGE. REFER TO MEMBER'S SPECIFIC BENEFIT PLAN BOOKLET TO VERIFY BENEFITS UNDER SERVICES TO DIAGNOSE INFERTILITY AND/OR FERTILITY AND INFERTILITY SERVICES.

If benefit coverage for fertility/infertility services is available, requests for fertility/infertility services will be reviewed by the medical director(s) and/or clinical advisor(s).

Resources:

Literature reviewed 09/04/18. We do not include marketing materials, poster boards and non-published literature in our review.

1. Blue Cross Blue Shield of Arizona Benefit Plan Booklet.

2. The Endocrine Society. Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism.* 07/02/2013.

3. The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People. 2012, Version 7.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Non-Discrimination Statement:

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Multi-Language Interpreter Services:

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínígíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídílkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yina'ídilkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowolgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 877-475-4799.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Multi-Language Interpreter Services: (cont.)

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue Cross Blue Shield of Arizona داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
تماس حاصل نمایید.]

Assyrian:
Blue Cross Blue Shield of Arizona
877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษา ของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

EXHIBIT E

Medical Coverage Policy

Effective Date..... 4/15/2019
Next Review Date..... 3/15/2020
Coverage Policy Number 0266

Treatment of Gender Dysphoria

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Preventive Care Services
Reduction Mammoplasty
Rhinoplasty, Vestibular Stenosis Repair, and Septoplasty
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Speech Therapy

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses treatment of gender dysphoria. Gender dysphoria is defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and the person's assigned sex at birth (World Professional Association for Transgender Health, [WPATH], 2012).

Coverage Policy

Coverage for treatment of gender dysphoria varies across plans. Refer to the customer's benefit plan document for coverage details. Coverage for treatment of gender dysphoria, including gender reassignment surgery and related may be governed by state and/or federal mandates.

Unless otherwise specified in a benefit plan, the following conditions of coverage apply for treatment of gender dysphoria and/or gender reassignment surgery and related procedures, including all applicable benefit limitations, precertification, or other medical necessity criteria.

SERVICES MEDICALLY NECESSARY

Medically necessary treatment for an individual with gender dysphoria may include ANY of the following services, when services are available in the benefit plan:

- Behavioral health services, including but not limited to, counseling for gender dysphoria and related psychiatric conditions (e.g., anxiety, depression)
- Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues, estrogens, and progestins.
- Laboratory testing to monitor prescribed hormonal therapy
- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individuals biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition)
- Gender reassignment and related surgery (see below).

Gender Reassignment Surgery

Gender reassignment surgery (see Table 1) is considered medically necessary treatment of gender dysphoria when the individual is age 18 years or older and when the following criteria are met:

- **For initial mastectomy:** one letter of support from a qualified mental health professional

  NOTE: The Women's Health and Cancer Rights Act (WHCRA), 29 U.S. Code § 1185b requires coverage of certain post-mastectomy services related to breast reconstruction and treatment of physical complications from mastectomy including nipple-areola reconstruction.

- **For hysterectomy, salpingo-oophorectomy, orchiectomy:**
  - documentation of at least 12 months of continuous hormonal sex reassignment therapy AND
  - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required.

- **For reconstructive genital surgery:**
  - documentation of at least 12 months of continuous hormonal sex reassignment therapy AND
  - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required AND
  - documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity.

Table 1: Gender Reassignment Surgery

Procedure	CPT / HCPCS codes (This list may not be all inclusive)
Initial mastectomy*, nipple-areola reconstruction (related to mastectomy or post mastectomy reconstruction)	19303, 19304, 19350
Hysterectomy and salpingo-oophorectomy	58150, 58260 58262 58291, 58552, 58554,

	58571, 58573, 58661
Female to male reconstructive genital surgery which may include any of the following: Vaginectomy**/colpectomy Vulvectomy Metoidioplasty Phalloplasty Electrolysis of donor site tissue to be used for phalloplasty Penile prosthesis (noninflatable / inflatable), including surgical correction of malfunctioning pump, cylinders, or reservoir Urethroplasty /urethromeatoplasty	55980 57110 56625 58999 58999 17380 54400, 54401, 54405, C1813, C2622 53430, 53450
Orchiectomy	54520, 54690
Male to female reconstructive genital surgery, which may include any of the following: Vaginoplasty**, (e.g, construction of vagina with/without graft, colovaginoplasty) Electrolysis of donor site tissue to be used to line the vaginal canal for vaginoplasty Penectomy Vulvoplasty, (e.g., labiaplasty, clitoroplasty, penile skin inversion) Repair of introitus Coloproctostomy	55970 57291, 57292, 57335 17380 54125 56620, 56805 56800 44145, 55899

***Note: Please reference the Cigna Medical Coverage Policy 0152 Reduction Mammoplasty for conditions of coverage related to breast reduction.**

****Note: For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months continuous hormonal sex reassignment therapy is required. An additional 12 months of hormone therapy is not required for vaginectomy or vaginoplasty procedures.**

NOT MEDICALLY NECESSARY SERVICES

Gender reassignment surgery is considered not medically necessary when the applicable medical necessity criteria for the procedure(s) has not been met.

Each of the following is excluded under many benefit plans and/or considered not medically necessary as part of gender reassignment for preservation of fertility (see Table 2):

Table: 2 Excluded and/or Not Medically Necessary- Fertility Preservation

Procedure	CPT/HCPCS Code
Cryopreservation of embryo, sperm, oocytes	89258, 89259, 89337
Procurement of embryo, sperm, oocytes	S4030, S4031
Storage of embryo, sperm, oocytes	89342, 89343, 89346, S4027, S4040

EXPERIMENTAL /INVESTIGATIONAL/UNPROVEN SERVICES

Each of the following is considered experimental, investigational or unproven as part of gender reassignment for the preservation of fertility (see Table 3):

Table: 3 Experimental, Investigational or Unproven - Fertility Preservation

Procedure	CPT/HCPCS Code
Cryopreservation of immature oocytes	0357T
Cryopreservation of reproductive tissue (i.e., ovaries, testicular tissue)	89335, 0058T
Storage of reproductive tissue (i.e., ovaries, testicular tissue)	89344
Thawing of reproductive tissue (i.e., ovaries, testicular tissue)	89354

COSMETIC SERVICES

Each of the following services (see Table 4) is considered cosmetic and/or not medically necessary for the purpose of improving or altering appearance or self-esteem related to one's appearance, including gender specific appearance for an individual with gender dysphoria:

Table 4: Cosmetic and/or Not Medically Necessary (Unless coverage is specifically listed as available in the applicable benefit plan document)

Facial Feminization/Masculinization Procedures	CPT/HCPCS Code
Blepharoplasty	15820, 15821, 15822, 15823
Cheek/malar implants	17999
Chin/nose implants	21210, 21270, 30400, 30410, 30420, 30430 30435, 30450
Collagen injections	11950, 11951, 11952, 11954
Face/forehead lift	15824, 15825, 15826, 15828, 15829, 21137
Facial bone reduction (osteoplasty)	21209
Hair removal/hair transplantation	15775, 15776, 17380
Jaw reduction	21120, 21121, 21122, 21223, 21125, 21127
Laryngoplasty	31599
Rhinoplasty	21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450
Skin resurfacing (e.g., dermabrasion, chemical peels)	15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793
Thyroid reduction chondroplasty	31750
Neck tightening	15825

Chest Reconstruction Procedures	CPT/HCPCS Code
Breast augmentation with implants	19324, 19325, 19340, 19342, C1789
Mastopexy	19316
Nipple/areola reconstruction (unrelated to mastectomy or post mastectomy reconstruction)	19350
Pectoral Implants	L8600, 17999

Voice Modification Therapy/Procedures	CPT/HCPCS Code
Voice modification surgery	31599, 31899
Voice therapy/voice lessons	92507

Other Miscellaneous Procedures	CPT/HCPCS Code
Abdominoplasty	15847

Calf implants	17999
Electrolysis, other than when performed pre-vaginoplasty as outlined above	17380
Insertion of testicular prosthesis	54660
Removal of redundant skin	15830, 15832, 15833, 15834, 15835, 15836 15837, 15838, 15839
Replacement of tissue expander with permanent prosthesis testicular insertion	11970
Scrotoplasty	55175, 55180
Suction assisted lipoplasty, lipofilling, and/or liposuction	15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879
Testicular expanders, including replacement with prosthesis, testicular prosthesis	11960, 11970, 11971, 54660

General Background

The causes of gender dysphoria and the developmental factors associated with them are not well-understood. Treatment of individuals with gender dysphoria varies, with some treatments involving a change in gender expression or body modifications. The term “transsexual” refers to an individual whose gender identity is not congruent with their genetic and/or assigned sex and usually seeks hormone replacement therapy (HRT) and possibly gender-affirmation surgery to feminize or masculinize the body and who may live full-time in the crossgender role. Transsexualism is a form of gender dysphoria. Other differential diagnoses include, but are not limited to, partial or temporary disorders as seen in adolescent crisis, transvestitism, refusal to accept a homosexual orientation, psychotic misjudgments of gender identity and severe personality disorders (Becker, et al., 1998). Individuals that are transsexual, transgender, or gender nonconforming (i.e., gender identity differs from the cultural norm) may experience gender dysphoria.

Treatment of gender dysphoria is unique to each individual and may or may not involve body modifications. Some individuals require only psychotherapy, some require a change in gender roles/expression, and others require hormone therapy and/or surgery to facilitate a gender transition.

Behavioral Health Services

Licensing requirements and scope of practice vary by state for healthcare professionals. WPATH has defined recommended minimum credentials for a mental health professional to be qualified to evaluate or treat adult individuals with gender dysphoria. In addition to general licensing requirements, WPATH includes a minimum of a Master’s or more advanced degree from an accredited institution, an ability to recognize and diagnose coexisting mental health concerns, and an ability to distinguish such conditions from gender dysphoria. Mental health professionals play a strong role in working with individuals with gender dysphoria as they need to diagnose the gender disorder and any co-morbid psychiatric conditions accurately, counsel the individual regarding treatment options, and provide psychotherapy (as needed) and assess eligibility and readiness for hormone and surgical therapy. For children and adolescents, the mental health professional should also be trained in child and adolescent developmental psychopathology.

Once the individual is evaluated, the mental health professional provides documentation and formal recommendations to medical and surgical specialists. Documentation for hormonal and/or surgery should be comprehensive and include the extent to which eligibility criteria have been met (i.e., confirmed gender dysphoria, capacity to make a fully informed decision, age ≥ 18 years or age of majority, and other significant medical or behavioral health concerns are well-controlled), in addition to the following:

- individual’s general identifying characteristics
- the initial and evolving gender, sexual and psychiatric diagnoses
- details regarding the type and duration of psychotherapy or evaluation the individual received
- the mental health professional’s rationale for hormone therapy or surgery
- the degree to which the individual has followed the standards of care and likelihood of continued compliance

- whether or not the mental health professional is a part of a gender team

For breast surgery WPATH Standards of Care Version 7 require one referral from a qualified mental health professional, as defined above. For genital surgery WPATH requires two referrals from qualified mental health professionals indicating criteria for surgery has been met. In contrast, the Endocrine Society Clinical Practice Guidelines (Hembree, et al., 2009) recommend both an endocrinologist responsible for endocrine transition therapy and a mental health professional certify the individual is eligible and meets WPATH criteria for gender reassignment surgery.

Psychiatric care may need to continue for several years after gender reassignment surgery, as major psychological adjustments may continue to be necessary. Other providers of care may include a family physician or internist, endocrinologist, urologist, plastic surgeon, general surgeon and gynecologist. The overall success of the surgery is highly dependent on psychological adjustment and continued support.

After diagnosis, the therapeutic approach is individualized but generally includes three elements: sex hormone therapy of the identified gender, real life experience in the desired role, and surgery to change the genitalia and other sex characteristics.

Hormonal Therapy

For both adults and adolescents, hormonal treatment for gender dysphoria must be administered and monitored by a qualified healthcare practitioner as therapy requires ongoing medical management, including physical examination and laboratory evaluation studies to manage dosage, side effects, etc. Lifelong maintenance is usually required.

Adults: Prior to and following gender reassignment surgery, individuals undergo hormone replacement therapy, unless medically contraindicated. Biological males are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. Biological females are treated with androgens such as testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. In both sexes hormone replacement therapy (HRT) may be effective in reducing the adverse psychologic impact of gender dysphoria. Hormone therapy is usually initiated upon referral from a qualified mental health professional or a health professional competent in behavioral health and gender dysphoria treatment specifically. Twelve months of continuous hormone therapy (gender appropriate) is required prior to hysterectomy and salpingo-oophorectomy and orchiectomy.

Adolescents: Puberty-suppressing hormones (e.g., GnRH analogues) for adolescents may be provided to individuals who have reached at least Tanner stage 2 of sexual development. The Endocrine Society supports puberty suppression and has developed criteria for a subset of individuals who fulfill and meet eligibility readiness for gender reassignment (Hembree, et al., 2009). WPATH clinical recommendations also support puberty suppression (WPATH, 2012) for a similar subset of individuals. Consistent with adult hormone therapy, treatment of adolescents involves a multidisciplinary team, however when treating an adolescent a pediatric endocrinologist should be included as a part of the team. Pre-pubertal hormone suppression differs from hormone therapy used in adults and may not be without consequence; some pharmaceutical agents may cause negative physical side effects (e.g., height, bone growth).

Gender Reassignment Surgery

The term "gender reassignment surgery," also known as sexual reassignment surgery, gender confirming surgery or gender affirmation surgery, may be part of a treatment plan for gender dysphoria. The terms may be used to refer to either the reconstruction of male or female genitalia specifically, or the reshaping by any surgical procedure of a male body into a body with female appearance, or vice versa.

Gender identity disorder does not persist into adolescence in most children (Hembree, et al., 2009). Evidence suggests that 75-80% of prepubertal children do not turn out to be transsexual in adolescence (Hembree, et al., 2009). According to WPATH (2007) persistence of gender dysphoria from adolescence into adulthood is much higher. Performing gender reassignment surgery prior to age 18, or the legal age to give consent, is not recommended by professional societies (American College of Obstetricians and Gynecology [ACOG], 2017;

WPATH, 2012; American Psychiatric Association (APA), 2012, Endocrine Society, 2009). Gender reassignment surgery is intended to be a permanent change (non-reversible), establishing congruency between an individual's gender identity and physical appearance. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrine and urological examination, and a clinical psychiatric/psychological examination. Individuals who choose to undergo gender reassignment surgery must be fully informed regarding treatment options with confirmation from the mental health professional that the individual is considered a candidate for surgical treatment.

Twelve months of continuous hormone therapy is required prior to irreversible genital surgery. In addition, prior to surgery the individual identified with gender dysphoria must undergo a "real life experience," in which he/she adopts the new or evolving gender role and lives in that role for at least 12 continuous months as part of the transition pathway. This process assists in confirming the person's desire for gender role change, ability to function in this role long-term, as well as the adequacy of his/her support system. During this time, a person would be expected to maintain their baseline functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role.

Other Associated Surgical Procedures

Services Otherwise Medically Necessary: Age appropriate gender-specific services that would otherwise be considered medically necessary remain medically necessary services for transgender individuals, as appropriate to their biological anatomy. Examples include (but are not limited to):

- for female to male transgender individuals who have not undergone a mastectomy, breast cancer and cervical cancer screening
- for male to female transgender individuals who have retained their prostate cancer screening or treatment of a prostate condition.

Reversal of Gender Reassignment: Gender reassignment surgery is considered an irreversible intervention (WPATH, 2012). Although infrequent, surgery to reverse a partially or fully completed gender reassignment (reversal of surgery to revise secondary sex characteristics), may be necessary as a result of a complication (i.e., infection) or other medical condition necessitating surgical intervention.

Fertility Preservation: Both hormone therapy and gender reassignment surgery limits fertility, and individuals should be informed of sperm preservation options and other cryopreservation services prior to starting hormone therapy. Reproductive options should also be discussed prior to surgery for individuals who are of child-bearing age. However, procedures aimed at preservation of fertility (e.g., procurement, cryopreservation, and storage of sperm, oocytes and/or embryos) performed prior to gender reassignment surgery are considered not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations, and applicable Cigna Medical Coverage Policy for conditions of coverage.

Cosmetic Procedures: Various other surgical procedures may be performed as part of gender reassignment surgery. Although WPATH does not define medical necessity criteria for masculinization and feminization procedures, referral by a qualified mental health professional is recommended. When performed as part of gender reassignment surgery such procedures, aimed primarily at improving personal appearance (i.e., masculinization, feminization), are performed to assist with improving culturally appropriate male or female appearance characteristics and are therefore considered cosmetic and are not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations, and applicable Cigna Medical Coverage Policy for conditions of coverage.

Professional Society/Organization

American College of Obstetricians and Gynecologists (ACOG): ACOG published a Committee Opinion in 2017 for the care of transgender adolescents. Within this document regarding surgical management ACOG notes transgender male patients may undergo phalloplasty when one reaches the age of majority, and a transgender female patient may undergo vaginoplasty when one reaches the age of majority. In addition the authors acknowledge the Endocrine Society guidelines (Hembree, et al., 2009) which state that an individual is at least age 18 years for genital reconstructive surgery (ACOG, 2017).

American Psychiatric Association (APA): In 2012 the APA published a task force report on treatment of gender identity disorder. Within this document, regarding adolescents specifically, the authors state the evidence is inadequate to develop a guideline regarding the timing of sex reassignment surgery. However the task force acknowledges the Endocrine Society guidelines (Hembree, et al., 2009) and that given the irreversible nature of surgery, for adolescents most clinicians advise waiting until the individual has attained the age of legal consent and a degree of independence (APA, 2012).

WPATH Standards of Care: The World Professional Association for Transgender Health (WPATH) promotes standards of health care for individuals through the articulation of "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" (WPATH, 2012, Version 7). WPATH standards of care are based on scientific evidence and expert consensus and are commonly utilized as clinical recommendations for individuals seeking treatment of gender disorders.

Endocrine Society: In 2009 the Endocrine Society published a clinical practice guideline for endocrine treatment of transsexual persons (Hembree, et al., 2009). As part of this guideline, the endocrine society recommends that transsexual persons consider genital sex reassignment surgery only after both the physician responsible for endocrine transition therapy and the mental health professional find surgery advisable; that surgery be recommended only after completion of at least one year of consistent and compliant hormone treatment; and that the physician responsible for endocrine treatment medically clear the individual for sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery.

Centers for Medicare & Medicaid Services (CMS

- National Coverage Determination (NCD): No NCD found.
- Local Coverage Determination (LCD): No LCD found.

Use Outside of the US: Several other countries including the United Kingdom offer treatment options for individuals with gender dysphoria. Treatments are similar to those offered in the United States.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Intersex Surgery: Male to Female

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
55970†	Intersex surgery; male to female
	†**Includes only the following procedures:**
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55899††	Unlisted procedure, male genital system
56620	Vulvectomy simple; partial
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state

††**Note: Considered medically necessary when used to report Coloproctostomy.**

Intersex Surgery: Female to Male

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
55980†	Intersex surgery, female to male
	†**Includes only the following procedures:**
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19350††	Nipple/areola reconstruction
53430	Urethroplasty, reconstruction of female urethra
53450	Urethromeatoplasty, with mucosal advancement
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
56625	Vulvectomy simple; complete
57110	Vaginectomy, complete removal of vaginal wall
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58999†††	Unlisted procedure, female genital system (nonobstetrical)

††**Note: Considered medically necessary when performed as part of a mastectomy or breast reconstruction procedure following a mastectomy.**

†††**Note: Considered medically necessary when used to report metoidioplasty with phalloplasty.**

HCPCS Codes	Description
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable

ICD-10-CM Diagnosis Codes	Description
F64.0	Trans-sexualism

F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Generally Excluded/Not Medically Necessary:

CPT®* Codes	Description
89258	Cryopreservation; embryo(s)
89259	Cryopreservation; sperm
89337	Cryopreservation, mature oocyte(s)
89342	Storage (per year); embryo(s)
89343	Storage (per year); sperm/semen
89346	Storage (per year); oocyte(s)

HCPCS Codes	Description
S4027	Storage of previously frozen embryos
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit
S4040	Monitoring and storage of cryopreserved embryos, per 30 days

Considered Experimental/Investigational/Unproven:

CPT®* Codes	Description
89335	Cryopreservation, reproductive tissue, testicular
89344	Storage (per year); reproductive tissue, testicular/ovarian
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian
0058T	Cryopreservation; reproductive tissue, ovarian
0357T	Cryopreservation; immature oocyte(s)

Considered Cosmetic and/or not medically necessary when performed as a component of gender reassignment, even when coverage for gender reassignment surgery exists unless subject to a coverage mandate:

CPT®* Codes	Description
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary

	procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy, forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999†	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316	Mastopexy
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350††	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599†††	Unlisted procedure, larynx
31750	Tracheoplasty; cervical
31899††††	Unlisted procedure, trachea, bronchi
40799†††††	Unlisted procedure, lips
54660	Insertion of testicular prosthesis (separate procedure)
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

HCPCS Codes	Description
C1789	Prosthesis, breast (implantable)
L8600	Implantable breast prosthesis, silicone or equal

†**Note: Cosmetic and/or not medically necessary when used to report calf, cheek, malar or pectoral implants or fat transfers performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.**

††**Note: Cosmetic and/or not medically necessary when not performed as part of a mastectomy or breast reconstructive procedure.**

†††**Note: Cosmetic and/or not medically necessary when used to report laryngoplasty performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.**

††††**Note: Cosmetic and/or not medically necessary when used to report voice modification surgery performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.**

†††††**Note: Cosmetic and/or not medically necessary when used to report lip reduction/enhancement performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.**

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EXHIBIT F

UnitedHealthcare® Community Plan

UnitedHealthcare® Community Plan
Medical Policy

GENDER DYSPHORIA TREATMENT

Policy Number: CS145.F **Effective Date**: January 1, 2020

Instructions for Use

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- Speech Language Pathology Services

Commercial Policy

- Gender Dysphoria Treatment

APPLICATION

This policy does not apply to the state of Tennessee.

COVERAGE RATIONALE

See Benefit Considerations

Note: This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development.

Gender reassignment surgery may be indicated for individuals who provide the following documentation:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria is needed for breast surgery. The assessment must document that an individual meets **all** of the following criteria:
  - Persistent, well-documented Gender Dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age (age of majority)
  - If significant medical or mental health concerns are present, they must be reasonably well controlled
- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the individual, are required for genital surgery. The assessment must document that an individual meets **all** of the following criteria:
  - Persistent, well-documented Gender Dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age (age of majority)
  - If significant medical or mental health concerns are present, they must be reasonably well controlled
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated)
- Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating Gender Dysphoria.

*See the Optum Coverage Determination Guideline titled *Gender Dysphoria* for provider qualification criteria (to access this guideline, go to: Optum Provider Express > Clinical Resources > Guidelines/Policies/Manuals > Coverage Determination Guidelines).

When the above criteria are met, the following gender reassignment surgical procedures are medically necessary and covered as a proven benefit:

- **Male-to-Female (MtF)**:
  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)
  - Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of gender dysphoria
- **Female-to-Male (FtM)**:
  - Bilateral mastectomy or breast reduction*
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prostheses
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)
  - Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of gender dysphoria

*Bilateral mastectomy or breast reduction may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the individual does not need to complete hormone therapy prior to procedure.

Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary when performed as part of gender reassignment:

- Abdominoplasty (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)
- Blepharoplasty (also see the Coverage Determination Guideline titled Blepharoplasty, Blepharoptosis and Brow Ptosis Repair)
- Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)
- Breast enlargement, including augmentation mammaplasty and breast implants
- Brow lift
- Calf implants
- Cheek, chin and nose implants
- Face/forehead lift and/or neck tightening
- Facial bone remodeling for facial feminization
- Hair transplantation
- Injection of fillers or neurotoxins (also see the Medical Benefit Drug Policy titled Botulinum Toxins A and B)
- Laser or electrolysis hair removal not related to genital reconstruction
- Lip augmentation
- Lip reduction
- Liposuction (suction-assisted lipectomy) (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)
- Mastopexy
- Pectoral implants for chest masculinization
- Rhinoplasty (also see the Coverage Determination Guideline titled Rhinoplasty and Other Nasal Surgeries)
- Skin resurfacing (e.g., dermabrasion, chemical peels, laser)
- Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
- Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords)
- Voice lessons and voice therapy

DEFINITIONS

Gender Dysphoria in Adolescents and Adults: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least two** of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender Dysphoria in Children: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least six** of the following (**one of which must be criterion A1**):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
   3. A strong preference for cross-gender roles in make-believe play or fantasy play
   4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
   5. A strong preference for playmates of the other gender
   6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities
   7. A strong dislike of one's sexual anatomy
   8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender

B. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

CPT Code	Description
15750	Flap; neurovascular pedicle
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area

CPT Code	Description
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
21899	Unlisted procedure, neck or thorax
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair

CPT Code	Description
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

CPT Code	Description
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral;
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

ICD-10 Diagnosis Code	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

DESCRIPTION OF SERVICES

Gender Dysphoria is a condition in which there is a marked incongruence between an individual's experienced/expressed gender and assigned gender (DSM-5). Treatment options include behavioral therapy, psychotherapy, hormone therapy and surgery for gender reassignment, which can involve genital reconstruction surgery and breast/chest surgery. For the FtM patient, surgical procedures may include mastectomy, hysterectomy, salpingo-oophorectomy, vaginectomy, vulvectomy, scrotoplasty, urethroplasty, placement of testicular and/or penile prostheses and phalloplasty or metoidioplasty (alternative to phalloplasty). For the MtF patient, surgical procedures may include penectomy, vaginoplasty, clitoroplasty, labiaplasty, orchiectomy and urethroplasty.

Other terms used to describe surgery for Gender Dysphoria include sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex reassignment.

BENEFIT CONSIDERATIONS

Coverage Information

Unless otherwise specified, if a plan covers treatment for gender dysphoria, coverage includes psychotherapy, cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. This benefit also includes certain surgical treatments listed in the Coverage Rationale section. See the Medical Benefit Drug Policy titled Gonadotropin Releasing Hormone Analogs.

Limitations and Exclusions

Certain treatments and services are not covered. Examples include, but are not limited to:

- Treatment received outside of the United States
- Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus (please check the federal, state or contractual requirements for benefit coverage)
- Transportation, meals, lodging or similar expenses
- Cosmetic procedures (see Coverage Determination Guideline titled Cosmetic and Reconstructive Procedures and the Coverage Rationale section)
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics

Benefits are limited to one sex transformation reassignment per lifetime which may include several staged procedures.

Coverage does not apply to members who do not meet the indications listed in the Coverage Rationale section.

CLINICAL EVIDENCE

An ECRI special report systematically reviewed the clinical literature to assess the efficacy of treatments for gender dysphoria. The authors identified limited evidence from mostly low-quality retrospective studies. Evidence on gender reassignment surgery was mostly limited to evaluations of MtF individuals undergoing vaginoplasty, facial feminization surgery and breast augmentation. Outcomes included mortality, patient satisfaction, physical well-being, psychological-related outcomes, quality of life, sexual-related outcomes, suicide and adverse events. Concluding remarks included the need for standardized protocols and prospective studies using standardized measures for correct interpretation and comparability of data (ECRI, 2016).

A Hayes report concluded that, overall, the quality of the evidence on gender reassignment surgery for gender dysphoria was very low (Hayes, 2014a; updated 2018). The evidence suggests positive benefits, but because of serious limitations, permits only weak conclusions. Limitations include small sample sizes, retrospective data, lack of randomization and control and a lack of objective and validated outcome measures.

- Patients who underwent chest/breast or genital surgery were generally pleased with the aesthetic results.
- Following gender reassignment surgery, patients reported decreased gender dysphoria, depression and anxiety and increased quality of life.
- The majority of gender reassignment surgery patients were sexually active, but the ability to orgasm varied across studies.
- Complications of surgery following gender reassignment surgery were common and could be serious.
- Rates of regret of surgery and suicide were very low following gender reassignment surgery.
- Data were too sparse to draw conclusions regarding whether gender reassignment surgery conferred additional benefits to hormone therapy alone.
- Data were too sparse to draw conclusions regarding whether outcomes vary according to which surgeries were performed.

A separate Hayes report concluded that, overall, the quality of the evidence on ancillary procedures for the treatment of gender dysphoria was very low (Hayes, 2014b; updated 2018). There is some evidence that transgender patients are satisfied with the results of rhinoplasty and facial feminization surgery, but patient satisfaction with vocal cord surgery and voice training was mixed. The evidence has serious limitations, and the effect of these procedures on overall individual well-being is unknown.

- Patients who had rhinoplasty or facial feminization surgery were generally pleased with the results.
- Vocal cord procedures and voice training had variable outcomes. Although the fundamental frequency was reduced by all treatment methods, patient satisfaction with the outcome was mixed.
- Most of the studies did not report complications; however, there was a low rate of bone nonunion following facial surgery, and moderate rates of dysphagia or throat pain following cricothyroid approximation.

Mahfouda et al. (2019) conducted a systematic review of the the available published evidence on gender-affirming cross-sex hormone (CSH) and surgical interventions in transgender children and adolescents, amalgamating findings on mental health outcomes, cognitive and physical effects, side-effects, and safety variables. The small amount of available data suggest that when clearly indicated in accordance with international guidelines, gender-affirming CSHs and chest wall masculinisation in transgender males are associated with improvements in mental health and quality of life. Evidence regarding surgical vaginoplasty in transgender females younger than age 18 years remains extremely scarce and conclusions cannot yet be drawn regarding its risks and benefits in this age group. Further research on an international scale is urgently warranted to clarify long-term outcomes on psychological functioning and safety.

Dreher et al. (2018) conducted a systematic review and meta-analysis to evaluate the epidemiology, presentation, management, and outcomes of neovaginal complications in the MtF transgender reassignment surgery patients. Selected studies reported on 1,684 patients with an overall complication rate of 32.5% and a reoperation rate of 21.7% for non-esthetic reasons. The most common complication was stenosis of the neo-meatus (14.4%). Wound infection was associated with an increased risk of all tissue-healing complications. Use of sacrospinous ligament fixation (SSL) was associated with a significantly decreased risk of prolapse of the neovagina. The authors concluded that gender-affirmation surgery is important in the treatment of gender dysphoric patients, but there is a high complication rate in the reported literature. Variability in technique and complication reporting standards makes it difficult to assess the accurately the current state of MtF gender reassignment surgery. Further research and implementation of standards is necessary to improve patient outcomes.

Manrique et al (2018) conducted a systematic review of retrospective studies on the outcomes of MtF vaginoplasty to minimize surgical complications and improve patient outcomes for transgender patients. Forty-six studies met the authors eligibility criteria. A total of 3716 cases were analyzed. The results showed the overall incidence of complications as follows: 2% fistula, 14% stenosis and strictures, 1% tissue necrosis, and 4% prolapse. Patient-reported outcomes included a satisfaction rate of 93% with overall results, 87% with functional outcomes, and 90% with esthetic outcomes. Ability to have orgasm was reported in 70% of patients. The regret rate was 1%. The authors concluded that multiple surgical techniques have demonstrated safe and reliable means of MtF vaginoplasty with low overall complication rates and with a significant improvement in the patient's quality of life. Studies using different techniques in a similar population and standardized patient-reported outcomes are required to further analyze outcomes among the different procedures and to establish best-practice guidelines.

Van Damme et al. (2017) conducted a systematic review of the effectiveness of pitch-raising surgery performed in MtF transsexuals. Twenty studies were included: eight using cricothyroid approximation, six using anterior glottal web formation and six using other surgery types or a combination of surgical techniques. A substantial rise in postoperative frequency was identified. The majority of patients seemed satisfied with the outcome. However, none of the studies used a control group and randomization process. Further investigation regarding long-term results using a stronger study design is necessary.

Morrison et al. (2016) conducted a systematic review of the facial feminization surgery literature. Fifteen studies were included, all of which were either retrospective or case series/reports. The studies covered a variety of facial feminization procedures. A total of 1121 patients underwent facial feminization surgery, with seven complications reported, although many studies did not explicitly comment on complications. Satisfaction was high, although most studies did not use validated or quantified approaches to address satisfaction. The authors noted that further studies are needed to better compare different techniques to more robustly establish best practices. Prospective studies and patient-reported outcomes are needed to establish quality of life outcomes for patients.

Frey et al. (2016) conducted a systematic review of metoidioplasty and radial forearm flap phalloplasty (RFFP) in FtM transgender genital reconstruction. Eighteen studies were included: 7 for metoidioplasty and 11 for RFFP. The quality of evidence was low to very low for all included studies. In studies examining metoidioplasty, the average study size and length of follow-up were 54 patients and 4.6 years, respectively (1 study did not report [NR]). Eighty-eight percent underwent a single-stage reconstruction, 87% reported an aesthetic neophallus (3 NR) and 100% reported erogenous sensation (2 NR). Fifty-one percent of patients reported successful intercourse (3 NR) and 89% of patients achieved standing micturition (3 NR). In studies examining RFFP, the average study size and follow-up were 60.4 patients and 6.23 years, respectively (6 NR). No patients underwent single-stage reconstructions (8 NR). Seventy percent of patients reported a satisfactorily aesthetic neophallus (4 NR) and 69% reported erogenous sensation (6 NR). Forty-three percent reported successful penetration of partner during intercourse (6 NR) and 89% achieved standing micturition (6 NR). Compared with RFFP, metoidioplasty was significantly more likely to be completed in a single stage, have an aesthetic result, maintain erogenous sensation, achieve standing micturition and have a lower overall complication rate. The authors reported that, although the current literature suggests that metoidioplasty is more likely to yield an "ideal" neophallus compared with RFFP, any conclusion is severely limited by the low quality of available evidence.

Using a retrospective chart review, Buncamper et al. (2016) assessed surgical outcome after penile inversion vaginoplasty. Outcome measures were intraoperative and postoperative complications, reoperations, secondary surgical procedures and possible risk factors. Of 475 patients who underwent the procedure, 405 did not have additional full-thickness skin grafts while 70 did have grafts. Median follow-up was 7.8 years. The most frequently observed intraoperative complication was rectal injury (2.3 percent). Short-term postoperative bleeding that required transfusion (4.8 percent), reoperation (1.5 percent) or both (0.4 percent) occurred in some cases. Major complications were three (0.6 percent) rectoneovaginal fistulas, which were successfully treated. Revision vaginoplasty was performed in 14 patients (2.9 percent). Comorbid diabetes was associated with a higher risk of local infection, and use of psychotropic medication predisposed to postoperative urinary retention. Successful vaginal construction without the need for secondary functional reoperations was achieved in the majority of patients.

Bouman et al. (2016) prospectively assessed surgical outcomes of primary total laparoscopic sigmoid vaginoplasty in 42 transgender women with penoscrotal hypoplasia. Mean follow-up time was 3.2 ± 2.1 years. The mean operative duration was 210 ± 44 minutes. There were no conversions to laparotomy. One rectal perforation was recognized during surgery and immediately oversewn without long-term consequences. The mean length of hospitalization was 5.7 ± 1.1 days. One patient died as a result of an extended-spectrum beta-lactamase-positive necrotizing fasciitis leading to septic shock, with multiorgan failure. Direct postoperative complications that needed laparoscopic reoperation occurred in three cases (7.1 percent). In seven cases (17.1 percent), long-term complications needed a secondary correction. After 1 year, all patients had a functional neovagina with a mean depth of 16.3 ± 1.5 cm.

Despite the significant increase in genital gender affirming surgery (GAS) within the past 50 years, there is limited data regarding hair removal practices in preparation for genital GAS. Genital gender affirming surgery (GAS) involves reconstruction of the genitals to match a patient's identified sex. The use of hair-bearing flaps in this procedure may result in postoperative intra-vaginal and intra-urethral hair growth and associated complications, including lower satisfaction with genital GAS. In 2016 Zhang et al conducted a literature review, recommendations from experience, and a practical laser hair removal (LHR) approach to hair removal prior to genital GAS.

Gaither et al. (2017) retrospectively reviewed the records of 330 MtF patients from 2011 to 2015, to assess surgical complications related to primary penile inversion vaginoplasty. Complications included granulation tissue, vaginal pain, wound separation, labial asymmetry, vaginal stenosis, fistula formation, urinary symptoms including spraying stream or dribbling, infection, vaginal fissure or vaginal bleeding. Median age at surgery was 35 years, and median followup in all patients was 3 months. The results showed that 95 of the patients presented with a postoperative complication with the median time to a complication being 4.4 months. Rectoneovaginal fistulas developed in 3 patients, and 30 patients required a second operation. Age, body mass index and hormone replacement therapy were not associated with complications. The authors concluded that penile inversion vaginoplasty is a relatively safe procedure. Most complications due to this surgery develop within the first 4 months postoperatively. Age, body mass index and hormone replacement therapy are not associated with complications and, thus, they should not dictate the timing of surgery.

Horbach et al. (2015) conducted a systematic review of vaginoplasty techniques in MtF individuals with gender dysphoria. Twenty-six studies were included (mostly retrospective case series of low to intermediate quality). Outcome of the penile skin inversion technique was reported in 1,461 patients and bowel vaginoplasty in 102 patients. Neovaginal stenosis was the most frequent complication in both techniques. Sexual function and patient satisfaction were overall acceptable, but many different outcome measures were used. Quality of life was only reported in one study. Comparison between techniques was difficult due to the lack of standardization. The authors concluded that the penile skin inversion technique is the most researched surgical procedure. Outcome of bowel vaginoplasty has been reported less frequently but does not seem to be inferior. The available literature is heterogeneous in patient groups, surgical procedure, outcome measurement tools and follow-up. There is a need for prospective studies with standardized surgical procedures, larger patient groups and longer follow-up periods. Uniformity in outcome measurement tools such as validated questionnaires and scores for sexual function and quality of life is mandatory for correct interpretation and comparability of data.

Bouman et al. (2014) conducted a systematic review of surgical techniques and clinical outcomes of intestinal vaginoplasty. Twenty-one studies were included (n=894). All studies had a retrospective design and were of low quality. Prevalence and severity of procedure-related complications were low. The main postoperative complication was introital stenosis, necessitating surgical correction in 4.1% of sigmoid-derived and 1.2% of ileum-derived vaginoplasties. Neither diversion colitis nor cancer was reported. Sexual satisfaction rate was high, but standardized questionnaires were rarely used. Quality of life was not reported. The authors concluded that prospective studies, using standardized measures and questionnaires, are warranted to assess functional outcomes and quality of life.

Murad et al. (2010) conducted a systematic review to evaluate the effects of hormone therapy on patients undergoing gender reassignment surgery. The authors identified 28 eligible studies, all of which were observational and most lacked controls. These studies enrolled 1833 participants with gender dysphoria (1093 MtF; 801 FtM). After gender

reassignment surgery, individuals reported improvement in gender dysphoria (80%), psychological symptoms (78%), sexual function (72%) and quality of life (80%). The authors concluded that very low quality evidence suggests that gender reassignment, that includes hormonal interventions, is likely to improve gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life.

Sutcliffe et al. (2009) systematically reviewed five individual procedures for MtF gender reassignment surgery: clitoroplasty, labiaplasty, orchiectomy, penectomy and vaginoplasty. Further evaluations were made of eight surgical procedures for FtM gender reassignment surgery: hysterectomy, mastectomy, metoidioplasty, phalloplasty, salpingo-oophorectomy, scrotoplasty/placement of testicular prostheses, urethroplasty and vaginectomy. Eighty-two published studies (38 MtF; 44 FtM) were included in the review. For MtF procedures, the authors found no evidence that met the inclusion criteria concerning labiaplasty, penectomy or orchiectomy. A large amount of evidence was available concerning vaginoplasty and clitoroplasty procedures. The authors reported that the evidence concerning gender reassignment surgery in both MtF and FtM individuals with gender dysphoria has several limitations including lack of controlled studies, lack of prospective data, high loss to follow- up and lack of validated assessment measures. Some satisfactory outcomes were reported, but the magnitude of benefit and harm for individual surgical procedures cannot be estimated accurately using the current available evidence.

Djordjevic et al. (2013) evaluated 207 patients who underwent single-stage metoidioplasty, comparing two different surgical techniques of urethral lengthening. The procedure included lengthening and straightening of the clitoris, urethral reconstruction and scrotoplasty with implantation of testicular prostheses. Buccal mucosa graft was used in all cases for dorsal urethral plate formation and joined with one of the two different flaps: longitudinal dorsal clitoral skin flap (n=49) (group 1) and labia minora flap (n=158) (group 2). The median follow-up was 39 months. The total length of reconstructed urethra ranged from 9.1 to 12.3 cm in group 1 and from 9.4 to 14.2 cm in group 2. Voiding while standing was significantly better in group 2 (93%) than in group 1 (87.82%). Urethral fistula occurred in 16 patients in both groups. Overall satisfaction was noted in 193 patients. The authors concluded that combined buccal mucosa graft and labia minora flap was the method of choice for urethroplasty in metoidioplasty, minimizing postoperative complications.

A single-arm study by Weigert et al. (2013) evaluated patient satisfaction with breasts and psychosocial, sexual and physical well-being after breast augmentation in MtF individuals with gender dysphoria. Thirty-five patients were asked to complete the BREAST-Q Augmentation module questionnaire before surgery, at 4 months and later after surgery. A prospective cohort study was designed and postoperative scores were compared with baseline scores. Responses indicated significant improvements in satisfaction with surgery (+59 points), psychosocial well-being (+48 points) and sexual well-being (+34 points). No significant changes were reported for physical well-being. This study has several limitations including lack of a control group and subjective measures.

In a non-randomized study, Dhejne et al. (2011) evaluated mortality, morbidity and criminal rates after gender reassignment surgery in 324 individuals (MtF n=191; FtM n=133). Random population controls (10:1) were matched by birth year and birth sex or reassigned final sex. The authors reported substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts and psychiatric hospitalizations in sex-reassigned individuals (both MtF/FtM) compared to a healthy control population. FtMs had a higher risk for criminal convictions.

World Professional Association for Transgender Health (WPATH)

WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, is an advocacy group devoted to transgender health. WPATH guidelines (2012) present eligibility and readiness criteria for transition-related treatment, as well as competencies of health care providers.

WPATH describes the transition from one gender to another in the following three stages:
- Living in the gender role consistent with gender identity
- The use of cross-sex hormone therapy after living in the new gender role for a least three months
- Gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months

Professional Societies

American College of Obstetrics and Gynecology (ACOG)

An ACOG committee opinion (2017) provides guidance on health care for transgender adolescents. The document makes the following recommendations regarding surgery:
- Obstetrician-gynecologists should understand gender identity and be able to treat transgender patients or refer them appropriately for medical and surgical therapeutic options.
- Surgical management for transgender male patients is typically reserved for patients 18 years and older.
- For transgender male patients, phalloplasty may be performed when the patient reaches the age of majority.
- Transgender female patients who choose to undergo surgery for a neovagina may have vaginoplasty after the age of majority.
- Transgender patients should be counseled about fertility and fertility preservation prior to surgical treatment.

A separate ACOG committee opinion (2011) provides guidance on health care for transgender individuals. The document makes the following recommendations regarding surgery:

- Obstetrician-gynecologists should assist or refer transgender individuals for routine treatment and screening as well as hormonal and surgical therapies.
- Hormonal and surgical therapies should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender persons.

Endocrine Society

Endocrine Society practice guidelines (Hembree et al., 2017) addressing endocrine treatment of gender-dysphoric/gender-incongruent persons makes the following recommendations regarding surgery for sex reassignment and gender confirmation:

- Suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country (Recommendation based on low quality evidence).
- A patient pursue genital gender-affirming surgery only after the mental health practitioner (MHP) and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being (Strong recommendation based on low quality evidence).
- Surgery is recommended only after completion of at least one year of consistent and compliant hormone treatment unless hormone therapy is not desired or medically contraindicated (Ungraded Good Practice Statement).
- The physician responsible for endocrine treatment medically clears individual for surgery and collaborates with the surgeon regarding hormone use during and after surgery (Ungraded Good Practice Statement).
- Recommend that clinicians refer hormone treated transgender individuals for genital surgery when (Strong recommendation based on very low quality evidence):
  - The individual has had a satisfactory social role change
  - The individual is satisfied about the hormonal effects
  - The individual desires definitive surgical changes
- Suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement (Recommendation based on very low quality evidence).

American Academy of Pediatrics (AAP)

In a 2018 policy statement entitled Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, the AAP states the following regarding surgery: Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults, they are occasionally pursued during adolescence on a case-by case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Gender reassignment surgeries are procedures, and therefore, not subject to FDA regulation. However, medical devices, drugs, biologics or tests used as a part of these procedures may be subject to FDA regulation. See the following website to search by product name: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed June 4, 2019)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does have a National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9). Local Coverage Articles (LCAs) also exist; refer to the LCAs for Gender Reassignment Services for Gender Dysphoria.
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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

01/01/2020	**Applicable Codes**
	• Updated list of applicable CPT codes to reflect annual code edits:
	  ○ Added 15769, 15771, 15772, 15773, and 15774
	  ○ Removed 19304 and 20926
	Supporting Information
	• Archived previous policy version CS145.E

INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

EXHIBIT G

August 10, 2018

RUSSELL TOOMEY
[redacted]

Member ID: [redacted]
Date of Service: October 1, 2018

Dear Russell Toomey:

Dr. Tiffany Woods Karsten has asked Blue Cross Blue Shield of Arizona (BCBSAZ) to approve you for a laparoscopic total hysterectomy with removal of tubes and ovaries surgery (58571) for your health issue of transsexualism and gender identity disorder (F64.0 and F64.9) at Tucson Medical Center. This is called "precertification." Your benefit plan requires you to get precertification for some services. A BCBSAZ Medical Director has reviewed the health care records your provider submitted.

Based upon that review, we cannot approve this request because the laparoscopic total hysterectomy with removal of tubes and ovaries surgery, for your diagnosis of transsexualism and gender identity disorder is considered a gender reassignment surgery, which is a benefit exclusion. This finding is based on your benefit plan booklet on pages 56 & 57 under the heading of "**Exclusions and General Limitations**" which states:

10.1 Exclusions and General Limitations

"In addition to any services and supplies specifically excluded in any other Article of the Plan Description, any services and supplies which are not described as covered are excluded. In addition, the following are specifically excluded Services and Supplies:

- Gender reassignment surgery."

If you choose to get the laparoscopic total hysterectomy with removal of tubes and ovaries surgery, BCBSAZ will not cover the costs of this service.

You have the right to appeal this decision. If you or your doctor chooses to proceed with the appeal process, you may call the appeal line and fax any additional supporting information. Your treating doctor may request an expedited appeal depending on medical urgencies.

Please see the reverse side of this letter for the BCBSAZ appeal and grievance procedures. You may submit your appeal by calling, faxing or mailing your request to:

Medical Appeals and Grievances Department A116
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466
Phone: (602) 544-4938 or (866) 595-5998
Fax: (602) 544-5601

Before appealing, a service determined not to be medically necessary is eligible for a peer to peer (PtoP) discussion. The treating provider may ask for a PtoP discussion. This may be done by calling the Office of the Medical Director at 602-864-4209 within 7 days from the date of this letter. PtoP discussions are not available for benefit exclusions, including, but not limited to:

- Investigational/Experimental decisions
- Out of Network requests for In-Network Level of Benefits
- Medication Doses outside of Federal Drug Administration (FDA) dosing levels

The Clinical Content you are receiving is confidential and proprietary information and is being provided to you solely as it pertains to the claim or the information request at issue. Under copyright law, the Clinical Content may not be copied, distributed, or otherwise reproduced. The Clinical Content is solely for use as a screening guide to assist in determining the medical appropriateness of health care services. All decisions about health care are strictly and solely the obligation and responsibility of a treating health care provider.

You also have the right to reasonable access to the medical records, InterQual medical criteria and any other information BCBSAZ used for this medical necessity benefit determination. BCBSAZ did not rely on any medical records except those furnished by your provider. If you would like a copy of these records or any documentation, please call us at the number above.

Sincerely,

Darren Deering, D.O.
Senior Medical Director

If you are hearing impaired (TDD), please call (602) 864-4823 or (800) 232-2345 ext.4823.

cc: TIFFANY WOODS KARSTEN MD
839 W CONGRESS ST
TUCSON AZ 85745

TUCSON MEDICAL CENTER
5301 E GRANT RD
TUCSON AZ 85712

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 877-475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, 602-864-2288, TTY/TDD 602-864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínígíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídílkidgo éí doodago Háída bíjá anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hólǫ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب .877-475-4799

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
[تماس حاصل نمایید.

Assyrian:

[illegible] Blue Cross Blue Shield of Arizona، [illegible]
[illegible] 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคณ หรอคนทคณกาลงชวยเหลอมคาถามเกยวกบ Blue Cross Blue Shield of Arizona
คณมสทธทจะไดรบความชวยเหลอและขอมลในภาษา ของคณไดโดยไมมคาใชจาย พดคยกบลาม โทร 877-475-4799