UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	NO. COMPLAINT

I. INTRODUCTION

1. Plaintiffs are a fifteen-year-old transgender boy (C.P.) and his mother (Patricia Pritchard) who are being discriminated against on the basis of sex because Plaintiff C.P. is transgender.

2. As part of the compensation for her employment, Plaintiff Patricia Pritchard receives health care coverage through the Catholic Health Initiatives Medical Plan ("Plan"), which is administered by Blue Cross Blue Shield of Illinois ("BCBSIL"). Plaintiff C.P. is enrolled in such Plan as a dependent of Ms. Pritchard.

3. Defendant BCBSIL is a "covered health entity" subject to Section 1557 of the Affordable Care Act ("ACA"). As a result, it may not discriminate on the basis of sex in the administration of health benefits. *See* 42 U.S.C. § 18116(a).

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4. Notwithstanding this requirement, BCBSIL administers the Plan according to its terms and in a manner that deprives transgender enrollees of coverage for medically-necessary treatment of gender dysphoria—the clinically significant distress that can result from the dissonance between an individual's gender identity and sex assigned at birth.

5. Specifically, at the time BCBSIL denied coverage for C.P.'s treatment, the terms of the Plan stated:

> ***Transgender Reassignment Surgery***
>
> Not Covered:
>
> Benefits shall not be provided for treatment, drugs, medicines, therapy, counseling services and supplies for, or leading to, gender reassignment surgery.

App. A, p. 61 (emphasis in original) (hereinafter referred to as the "Exclusion").

6. The sweeping exclusion contained within the Plan denies coverage for gender-affirming health care, including surgical care, and other health care provided in relation to a person's transgender status and/or gender transition, if BCBSIL determines that the care is provided "for or leading to gender reassignment surgery." In practice, in C.P.'s case, BCBSIL has denied coverage for C.P.'s surgical care including the implantation of his second Vantas implant, mastectomy and chest reconstruction.

7. The Exclusion contravenes the well-established medical consensus that gender-affirming health care can be medically necessary and even life-saving. Other Plan enrollees who are not transgender do not face a categorical exclusion barring coverage for health care that is medically necessary for them based on their sex and receive coverage for the same care that is denied to transgender enrollees.

8. Plaintiffs have been denied coverage for medically necessary gender affirming health care because C.P. is transgender, based on the Exclusion of gender-

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affirming health care in the Plan. Plaintiffs have been forced to incur financial hardship without the financial protection afforded by coverage through the Plan. Plaintiffs have also suffered emotional distress, stigmatization, humiliation, and a loss of dignity because of the Plan's targeted discrimination against transgender enrollees, which wrongly deems their health care needs as unworthy of equal coverage.

9. This targeted discrimination against transgender people, which BCBSIL administers and enforces, violates the ACA's Section 1557.

10. Plaintiffs bring this lawsuit to challenge BCBSIL's administration of the Plan's Exclusion despite the non-discrimination requirements of Section 1557 and to obtain a judgment to redress their individual injuries and to have the exclusion declared unlawful, thereby preventing its enforcement.

II. PARTIES

11. ***Plaintiff C.P.*** Plaintiff C.P. is a fifteen-year-old transgender boy who is enrolled in the Plan, a health plan administered by BCBSIL. C.P. brings suit by and through his next friends and parents, Patricia Pritchard and Nolle Pritchard.

12. ***Plaintiff Patricia Pritchard.*** Plaintiff Patricia Pritchard is the mother of C.P. She is employed at St. Michael Medical Center in Bremerton, Washington, which is part of the Catholic Health Initiatives Franciscan Health System, now known as CommonSpirit Health. As part of her employment, Ms. Pritchard receives health coverage through the Plan, as administered by BCBSIL. C.P. receives health coverage through the Plan as a dependent of Ms. Pritchard. Ms. Pritchard and C.P. live in Bremerton, Washington.

13. ***Blue Cross Blue Shield of Illinois.*** Defendant Blue Cross Blue Shield of Illinois (BCBSIL) is the claims administrator of the Plan's schedule of benefits in which Plaintiff C.P. is enrolled as a dependent of Ms. Pritchard. BCBSIL is a division of Health

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Care Service Corporation, a mutual legal reserve company headquartered in Chicago Illinois. Defendant BCBSIL is not a religious organization. BCBSIL is a recipient of federal financial assistance and participates in health care insurance marketplaces established under the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA").

III. JURISDICTION AND VENUE

14. This action arises under Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116.

15. This Court has original jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 because the matters in controversy arise under the Constitution and laws of the United States.

16. Declaratory relief is authorized by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by 28 U.S.C. §§ 2201 and 2202.

17. Venue is proper under 28 U.S.C. § 1391(b)(2), because, *inter alia*, a substantial part of the events giving rise to the claim occurred in Kitsap County.

18. The Court has personal jurisdiction over Defendant BCBSIL because by agreeing to administer the Plan, which covers residents of the State of Washington, BCBSIL has knowingly and deliberately engaged in significant activities within the State of Washington and has created continuing obligations between itself and residents of the this forum.

IV. FACTUAL BACKGROUND

19. Every individual's sex is multifaceted, and comprised of a number of characteristics, including but not limited to chromosomal makeup, hormones, internal and external reproductive organs, secondary sex characteristics, and most importantly, gender identity.

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20. Gender identity is a person's internal sense of their sex. It is an essential element of human identity that everyone possesses, and a well-established concept in medicine. Gender identity is innate, immutable, and has biological underpinnings.

21. For everyone, gender identity is the most important determinant of a person's sex and a fundamental component of human identity.

22. A person's sex is generally assigned at birth based solely on a visual assessment of external genitalia at the time of birth. External genitalia are only one of several sex-related characteristics and are not always indicative of a person's sex.

23. For most people, these sex-related characteristics are all aligned, and the visual assessment performed at birth serves as an accurate proxy for that person's gender.

24. Where a person's gender identity does not match that person's sex assigned at birth, however, gender identity is the critical determinant of that person's sex.

25. The ability to live in a manner consistent with one's gender identity is vital to the health and wellbeing of transgender people.

26. For transgender people, an incongruence between their gender identity and sex assigned at birth can result in a feeling of clinically significant stress and discomfort known as gender dysphoria.

27. Gender dysphoria is a serious medical condition recognized in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5"); the World Health Organization's International Classification of Diseases, which is the diagnostic and coding compendia for medical professionals; and by other leading medical and mental health professional groups, including the American Medical Association ("AMA") and the American Psychological

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Association ("APA"). The criteria for diagnosing gender dysphoria are set forth in the DSM-5 (302.85).

28. In addition to clinically significant distress, untreated gender dysphoria can result in severe anxiety, depression, or even suicidality.

29. Untreated gender dysphoria often intensifies with time. The longer an individual goes without or is denied adequate treatment for gender dysphoria, the greater the risk of severe harms to the individual's health.

30. Gender dysphoria can be treated in accordance with internationally recognized Standards of Care formulated by the World Professional Association for Transgender Health ("WPATH"). WPATH is an international, multidisciplinary, professional association whose mission is to promote evidence-based health care protocols for transgender people. WPATH publishes Standards of Care that are based on the best available science and expert professional consensus, and which are widely accepted as best practices for treating gender dysphoria.

31. Under the WPATH Standards of Care, medically necessary treatments may include, among other things, "[h]ormone therapy" and "[s]urgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring)."

32. The Standards of Care are recognized as authoritative by national medical and behavioral health organizations such as the AMA and APA, which have both called for an end to exclusions of gender-affirming care from health insurance and health benefit plans.

33. The individualized steps that many transgender people take to live in a manner consistent with their gender, rather than the sex they were assigned at birth, are known as transitioning.

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34. Transitioning is particular to the individual but typically includes social, legal, and medical transition.

35. Social transition entails a transgender individual living in accordance with their gender identity in all aspects of life. For example, social transition can include wearing attire, following grooming practices, and using pronouns consistent with that person's gender identity. The steps a transgender person can take as part of their social transition help align their gender identity with all aspects of everyday life.

36. Legal transition involves steps to formally align a transgender individual's legal identity with their gender identity, such as legally changing one's name and updating the name and gender marker on their driver's license, birth certificate, and other forms of identification.

37. Medical transition, a critical part of transitioning for many transgender people, includes gender-affirming care that bring the sex-specific characteristics of a transgender person's body into alignment with their gender. Gender-affirming care can involve counseling to obtain a diagnosis of gender dysphoria, hormone replacement therapy, surgical care, or other medically necessary treatments for gender dysphoria.

38. Hormone replacement therapy involves taking hormones for the purpose of bringing one's secondary sex characteristics into typical alignment with one's gender identity. Secondary sex characteristics are bodily features not associated with external and internal reproductive genitalia (primary sex characteristics). Secondary sex characteristics include, for example, hair growth patterns, body fat distribution, and muscle mass development. Hormone replacement therapy can have significant masculinizing or feminizing effects and can assist in bringing a transgender individual's secondary sex characteristics into alignment with their true sex, as determined by their

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gender identity, and therefore is medically necessary care for transgender people who need it to treat their gender dysphoria.

39. Gender-affirming surgical care might be sought by a transgender person to better align primary or secondary sex characteristics with their gender identity. Surgical care can include, but is not limited to, hysterectomies, gonadectomies, mammoplasties, mastectomies, orchiectomies, vaginoplasties, and phalloplasties. These treatments are for the purpose of treating gender dysphoria.

40. These various components associated with transition—social, legal, and medical transition—do not change an individual's sex, as that is already established by gender identity, but instead bring the individual's appearance, legal identity, and sex-related characteristics into greater alignment with the individual's gender identity and lived experience.

41. The consequences of untreated, or inadequately treated, gender dysphoria are dire. Symptoms of untreated gender dysphoria include intense emotional suffering, anxiety, depression, suicidality, and other attendant mental health issues. Untreated gender dysphoria is associated with higher levels of stigmatization, discrimination, and victimization, contributing to negative self-image and the inability to function effectively in daily life. When transgender people are provided with access to appropriate and individualized gender-affirming care in connection with treatment of gender dysphoria, these symptoms can be alleviated and even prevented.

42. The AMA, APA, American Psychiatric Association, Endocrine Society, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, and other major medical organizations have recognized that gender-affirming care is medically necessary, safe, and effective treatment for gender dysphoria—and that access to such treatment improves the health and well-being of

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transgender people. Each of these groups has publicly opposed exclusions of coverage of this treatment by private and public health care administrators and payors, like the Exclusion at issue here.

43. WPATH has stated that, like hormone replacement therapy and other gender-affirming treatments, the "medical procedures attendant to sex reassignment are not 'cosmetic' or 'elective' or for the mere convenience of the patient," but instead are "medically necessary for the treatment of the diagnosed condition." Nor are they experimental, because "decades of both clinical research and medical research show that they are essential to achieving well-being for the [transgender] patient."

44. Plaintiff C.P. is a boy who is transgender. That means that he was assigned the sex of female at birth but his gender identity is male.

45. C.P.'s birth certificate, social security identification, and passport all identify him as male. C.P. has identified and lived as male since 2015.

46. C.P. has been diagnosed with gender dysphoria.

47. Although BCBSIL and the Plan have covered some of C.P.'s past treatment for gender dysphoria, including injected testosterone medication, treatment by Kevin Hatfield, M.D., C.P.'s primary care provider, as well as mental health counseling related to this condition, BCBSIL has denied coverage for some of C.P.'s medically-necessary gender-affirming medical care because it is "for or leading to gender reassignment surgery."

48. On October 14, 2016, BCBSIL initially approved C.P.'s request for preauthorization for a Vantas implant, which is a treatment to delay the onset of female puberty and was prescribed by Dr. Hatfield as medically-necessary to treat C.P.'s gender dysphoria.

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49. On November 11, 2016, C.P. received the Vantas implant and sometime thereafter, payment for the services related to the implant was made by BCBSIL.

50. Despite the payment for services, on February 24, 2017, C.P.'s mother was told by a BCBSIL representative that coverage for the Vantas implant would be denied. ***App. B***.

51. On April 21, 2017, C.P.'s mother received a letter from BCBSIL indicated that coverage was denied because "treatment for transgender services were allowed incorrectly under the medical plan." ***App. C***.

52. On May 25, 2017, C.P.'s parents appealed the BCBSIL denial. ***App. D***.

53. On October 19, 2017, C.P.'s parents received a letter from BCBSIL indicating that the appeal had been received on June 2, 2017, and that a decision would be made within 15 calendar days, or June 17, 2017, a date that had long since passed. ***App. E***.

54. No formal response from BCBSIL was received by C.P.'s parents until April 26, 2018, eleven months after the appeal was submitted. ***App. F***. That letter denied coverage of the service because BCBSIL took the position that it was a "service related to gender-reassignment" and was therefore excluded under the Plan. However, BCBSIL indicated that it would not "clawback" the payments already made to C.P.'s providers related to the Vantas implant.

55. In 2017, the Plan did not include an exclusion of coverage for "gender-reassignment" treatment or treatment for gender dysphoria.

56. Starting January 1, 2018, the Plan added an exclusion for gender-affirming treatment. *See* ***App. A***.

57. BCBSIL administers and enforces the Plan Exclusion, denying coverage of medical care, treatment, and procedures when used to treat gender dysphoria even

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when such care, treatments, and procedures are medically necessary. BCBSIL applies the Exclusion even though it covers the same or similar procedures for other enrollees in the Plan.

58. BCBSIL applies and enforces the Exclusion even though BCBSIL has determined that it is illegal for BCBSIL to apply the same or similar Exclusion in its own insured health plans. *See, e.g.*, ***App. G***.

59. In 2018, C.P. was prescribed testosterone cream to treat his gender dysphoria.

60. After going through a lengthy appeals process, an attorney representing the Plan (***but not BCBSIL***) wrote to C.P.'s attorneys and indicated that the Plan's Exclusion was limited to only "gender reassignment surgery." ***App. H***. Specifically, he represented that "[I]n 2019, the only 'transgender health service' specifically excluded under the Plan is gender reassignment surgery."

61. In July 2019, C.P. and his parents met with his treating physician, Dr. Hatfield, and his therapist, Sharon Booker regarding C.P.'s need for a second Vantas implant and gender-affirming top surgery (specifically, chest reconstruction).

62. C.P.'s medical and mental health providers concluded that both procedures were medically necessary to treat his gender dysphoria. ***Apps. I, J***.

63. Requests for pre-authorization for both procedures were submitted to BCBSIL, and both were denied. ***Apps. K, L***.

64. C.P. proceeded to have the procedure for the second Vantas implant on November 6, 2019.

65. C.P. received chest reconstruction surgery on December 19, 2019.

66. On December 2, 2019, C.P. and his parents appealed the BCBSIL denial. ***App. M***.

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67. On December 23, 2019, BCBSIL issued a denial of the appeal, but claimed that "our prior response dated April 26, 2018 completed the internal appeal process that is available to you" even though the 2019 appeal filed by C.P.'s parents was for two different procedures and the relevant plan language had changed since the 2017 denial and appeal. *See* ***App. N***.

68. After BCBSIL denied the appeal, it appears to have covered some of the cost of the medications related to the second Vantas implant, but not other related costs. *See* ***App. O***. BCBSIL also continued to deny coverage of nearly all treatment related to C.P.'s mastectomy and chest reconstruction.

69. BCBSIL has never claimed that C.P.'s treatment for his gender dysphoria is not medically necessary or is "experimental and investigational."

70. In 2008, the AMA passed Resolution 122 recognizing gender dysphoria (then known as gender identity disorder) as a "serious medical condition" which, "if left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression, and for some people without access to appropriate medical care and treatment, suicidality and death." American Med. Ass'n, *Resolution 122: Removing Financial Barriers to Care for Transgender Patients* (June 16, 2008). The AMA also opposes categorical exclusions of coverage for treatment of gender dysphoria because "many of these same treatments … are often covered for other medical conditions" and "the denial of these otherwise covered benefits for patients suffering from [gender dysphoria] represents discrimination based solely on a patient's gender identity." *Id.*

71. In the past, public and private health administrators and payors excluded coverage for medically necessary treatment of gender dysphoria on the erroneous assumption that such treatments were cosmetic or experimental. Today, the medical

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consensus recognizes that exclusions of treatment for gender dysphoria on those grounds have no basis in medical science.

72. At all relevant times, BCBSIL was a "health program or activity" part of which receives federal financial assistance. 42 U.S.C. § 18116. As a result, BCBSIL was a "covered entity" under the Affordable Care Act, Section 1557.

73. BCBSIL provided assurances to the U.S. Department of Health and Human Services that it complies with the requirements of Section 1557. *See* 45 C.F.R. § 92.5.

74. BCBSIL also provided written assurances to C.P. and his parents that it would comply with the requirements of Section 1557. *See* ***App. E,*** p. 3; *see also* ***Apps. F, K,*** and ***L*** (same).

75. Despite these assurances, BCBSIL has administered the Plan's Exclusion of all treatment that BCBSIL construes to be "for, or leading to, gender reassignment surgery." BCBSIL continues to do so, to date.

76. BCBSIL agreed to administer the Exclusion in the Plan for Catholic Health Initiatives/CommonSpirit Health, even though BCBSIL knew that Plan enrollees with gender dysphoria needed medical treatment for their condition. It did so despite the non-discrimination assurances BCBSIL provided to the federal government and to the Plan's enrollees.

77. Based on information and belief, BCBSIL administered the Exclusion despite its own legal analysis that the Exclusion violates the Affordable Care Act's Section 1557.

78. BCBSIL has administered the Exclusion to deny coverage of medically necessary treatment for C.P., because the requested treatment would treat his gender dysphoria.

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79. As a result of BCBSIL's deliberate discriminatory actions, C.P. has not received coverage of medically necessary treatment for his gender dysphoria and his parents have incurred over $10,000 in out-of-pocket expenses.

80. C.P. and his parents anticipate that they will incur additional expenses related to his medically necessary treatment for gender dysphoria, if BCBSIL continues to administer and enforce the Plan's Exclusion.

81. BCBSIL's administration of the Exclusion denies transgender enrollees with gender dysphoria the benefits and health coverage available to other insureds. It is discrimination on the basis of sex, which includes discrimination on the basis of sex characteristics, gender identity, nonconformity with sex stereotypes, transgender status, and gender transition.

82. Plaintiff C.P. and his parents have appealed BCBSIL's denial of coverage for C.P.'s medically necessary treatment, but his appeals have been denied. While any further administrative appeals would be futile, no such appeal is required before a claim may be brought under §1557.

83. Because of BCBSIL's administration and enforcement of the Exclusion, Plaintiffs have suffered emotional distress, humiliation, degradation, embarrassment, emotional pain and anguish, violation of their dignity, loss of enjoyment of life, and other compensatory damages, in an amount to be established at trial.

V. CLAIM FOR RELIEF: VIOLATION OF AFFORDABLE CARE ACT § 1557, 42 U.S.C. § 18116

84. Plaintiffs re-allege and incorporate each of the allegations in the paragraphs above, as though fully set forth herein.

85. Section 1557 of the ACA, 42 U.S.C. § 18116, provides that "an individual shall not, on the ground prohibited under … title IX of the Education Amendments of 1972 … be excluded from participation in, denied the benefits of, or be subjected to

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discrimination under, any health program or activity, any part of which is receiving Federal financial assistance…." (emphasis added).

86. Defendant BCBSIL is a covered "health program or activity" a part of which receives federal financial assistance and is therefore a "covered entity" for purposes of Section 1557.

87. Discrimination on the basis of sex characteristics, gender identity, nonconformity with sex stereotypes, transgender status, or gender transition is discrimination on the basis of "sex" under Section 1557.

88. By administering the Plan's Exclusion as an exclusion of all medically necessary care "for, or leading to, gender reassignment surgery," BCBSIL has drawn a classification that discriminates on the basis of "sex." Specifically, BCBSIL has denied C.P. coverage for medically necessary services based on his sex, sex characteristics, gender identity, nonconformity with sex stereotypes, transgender status, or gender transition. Other enrollees whose gender identity conforms with their sex assigned at birth are able to receive these services, when medically necessary.

89. A covered entity, such as BCBSIL, cannot provide or administer health insurance or health benefit coverage which contains a categorical exclusion from coverage for gender-affirming health care, or otherwise impose limitations or restrictions on coverage for specific health services related to gender transition if such limitation or restriction results in discrimination against a transgender individual.

90. Because BCBSIL is a covered entity under Section 1557 of the ACA, Plaintiffs have a right under Section 1557 to receive health benefits administered by BCBSIL free from discrimination on the basis of sex, sex characteristics, gender identity, nonconformity with sex stereotypes, transgender status, or gender transition.

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91. BCBSIL continues to administer the Exclusion, despite the warning from the U.S. Department of Health and Human Services that "[a]n explicit, categorical (or automatic) exclusion or limitation of coverage for all health services related to gender transition is unlawful on its face." *See* 81 Fed. Reg. 31,429. It has done so despite the non-discrimination assurances it gave to the federal government and its enrollees. It has done so despite its own conclusion that to engage in such discrimination in its insured plans is illegal.

92. By excluding coverage of all health care related to gender dysphoria or any other care BCBSIL determines is "for, or leading to, gender reassignment surgery," BCBSIL has intentionally discriminated, and continues to discriminate on the basis of sex, against Plaintiffs C.P. and Patricia Pritchard in violation of Section 1557.

93. As a result of the Exclusion, Plaintiffs have suffered harm, including but not limited to financial harm. By knowingly and intentionally offering and administering health care coverage to Plaintiffs that discriminates on the basis of sex, BCBSIL has intentionally violated the ACA, for which Plaintiffs are entitled to compensatory damages, including but not limited to out-of-pocket damages, and consequential damages.

94. Without injunctive relief from the Plan's discriminatory Exclusion of coverage for gender-affirming care, Plaintiffs will continue to suffer irreparable harm in the future.

VI. DEMAND FOR RELIEF

WHEREFORE, Plaintiffs request that this Court:

1. Enter judgment on behalf of Plaintiffs due to BCBSIL's discrimination on the basis of sex in violation of the Affordable Care Act's Section 1557;

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2. Declare that BCBSIL violated Plaintiffs' rights under Section 1557 of the ACA when it administered and enforced the Plan's Exclusion of all treatment "for, or leading to, gender reassignment surgery," and/or other Plan provisions, policies or practices that wholly exclude or impermissibly limit coverage of gender-affirming health care;

3. Enjoin BCBSIL, its agents, employees, successors, and all others acting in concert with them, from administering or enforcing health benefit plans that exclude coverage for gender-affirming health care, including applying or enforcing the Plan's Exclusion "for, or leading to, gender reassignment surgery," and other similar exclusions in the health benefit plans BCBSIL administers and enforces, in violation of the Affordable Care Act now and in the future;

4. Enter judgment in favor of Plaintiffs for damages in an amount to be proven at trial due to BCBSIL's violation of Section 1557 of the Affordable Care Act;

5. Award Plaintiffs their attorney fees and costs under 42 U.S.C. §1988; and

6. Award such other relief as is just and proper.

DATED: November 23, 2020.

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APPENDIX A

Catholic Health Initiatives

Imagine better health.®

well-being

Summary Plan Description — Medical (Franciscan Health)

Blue Cross Blue Shield Integrated

Effective January 1, 2019

imagine your ***Best Self***

2019 Summary of Modifications

The changes listed below have been made to the Summary Plan Description for 2019.

Summary of Modifications

- Adding a diabetic management program
- Adding coverage for applied behavior analysis therapy
- Increasing the employer HSA contribution
- Eliminating coverage for artificial insemination

Who to Contact With Questions

Benefit	Contact	Applicable MBO
General		
General questions about eligibility for benefits, enrollment and qualified life event change, etc.	**HR/Payroll Connection Support Center** 3900 Olympic Blvd, Suite 400 Erlanger, KY 41018 844-450-9450 http://home.catholichealth.net/wellbeing	**National office employees**, Tacoma, WA **Franciscan Health System**, Tacoma, WA **Franciscan Medical Group**, Tacoma, WA

Benefit	Contact
Medical Benefits	
Questions about your coverage	**CHI Medical Plan Customer Service Team** Blue Cross Blue Shield of Illinois www.bcbsil.com/chi 1-866-776-4244
Find network providers	**CHI Medical Plan Customer Service Team** Blue Cross Blue Shield of Illinois www.bcbsil.com/chi 1-866-776-4244
Prenatal care program	**Virgin Pulse** http://home.catholichealth.net/wellbeing 75 Fountain Street, Suite 310 Providence, RI 02902 1-833-721-4094
Pre-certification	**CHI Medical Plan Customer Service Team** Blue Cross Blue Shield of Illinois 1-866-776-4244
Health savings account	**HealthEquity** www.healthequity.com/ed/chi 15 West Scenic Pointe Drive, Suite 400 Draper, UT 84020 1-866-212-4634
Prescription Benefits	
General questions about prescription benefits	**CVS/Caremark** www.caremark.com 1-877-232-7925
Prescription claims	**CVS/Caremark** www.caremark.com 1-877-232-7925

Table of Contents

Medical Plan Introduction

In accordance with the heritage of its participating congregations, Catholic Health Initiatives (CHI) emphasizes care of the whole person in body, mind, and spirit. This commitment is reflected not only in the care provided to the individuals and communities CHI serves, but also in the Benefits the organization provides to you, its Employees.

The Medical Plan will be administered by Blue Cross Blue Shield of Illinois and the pharmacy benefit will be administered by CVS/Caremark.

The plan has been established on a noninsured basis; all liability for payment of Benefits is assumed by CHI. While Blue Cross Blue Shield of Illinois and CVS/Caremark administer payment of Claims, Blue Cross Blue Shield of Illinois and CVS/Caremark have no liability for the funding of the Benefit plan.

While one of the functions of Blue Cross Blue Shield of Illinois and CVS/Caremark is to process Claims according to the plan provisions, all Claims paid under the plan are paid by CHI and CHI owns the Claim files. Therefore, the final decision on any disputed Claim may involve review of these files by CHI.

The Plan was established on January 1, 2001, and this Summary Plan Description, which provides detailed descriptions of the Benefits available to you, is revised as of January 1, 2019. This Summary Plan Description replaces all Summary Plan Descriptions and related amendments effective prior to January 1, 2019, relative to the Plan and shall remain in effect until further notice. Please read the information in this Summary Plan Description carefully so you will have a full understanding of your health care Benefits. If you want more information or have any questions about your health care Benefits, please contact the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card.

A copy of this SPD is available online by either:

- Logging into InsideCHI. (Go to HR/Payroll Connection>My Policies Menu> Health and Welfare Plan Documents. Under Browse, search “SPD.”)
- If you prefer a paper copy, you may print it locally. If you do not have access to a printer locally you may request a copy by contacting the HR/Payroll Connection Support Center at 1-844-450-9450.

Important Information

CHI reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time for any reason. This Summary Plan Description also constitutes the Plan Document. Nothing in this Summary Plan Description constitutes a promise of continued employment.

Charts and Call-Out Boxes

Some sections of this Summary Plan Description have charts and/or call-out boxes, which provide a quick reference or summary, but they are not a complete description of all details about a topic. A particular chart or call-out box may not describe some significant factors that would help determine your Benefits, payments, or other responsibilities. Where examples are given, the dollar amounts

provided are strictly to help you understand the concept and are not intended to reflect the actual or typical cost for such a service.

It is important for you to learn about all of the details of a topic and follow any references to other sections of the Summary Plan Description. (References tell you to "see" a section or subject heading, such as, "see *The Details — What's Covered and Not Covered*." References may also include a page number.)

Complete Information

Very often, complete information on a subject requires you to consult more than one section of the Summary Plan Description. For your convenience we have included a *Glossary of Terms* that defines the meanings of words found throughout this Summary Plan Description that are written in capital letters and have very specific meanings.

Most information on Benefits will be found in these sections:

- *Highlights of the Medical Plan Options*
- *Quick Reference — What's Covered and Not Covered*
- *The Details — What's Covered and Not Covered*
- *General Conditions of Coverage, Exclusions, and Limitations*

However, Benefits might also be affected by your choice of Provider (see *Network Details — Choosing a Provider*), certain notification requirements (see *Medical and Pharmacy Notification Requirements and Care Coordination*), and considerations of eligibility (see *Adding or Dropping Coverage*).

Even if a service is listed as covered, Benefits might not be available in certain situations, and even if a service is not specifically described as being excluded, it might not be covered.

You can use your Medical Plan to your best advantage by learning how this Summary Plan Description is organized and how sections are related to each other. Whenever you look up a particular topic, be sure to follow any references and read thoroughly.

Highlights of the Medical Plan Options

This chart summarizes your Benefit options and payment responsibilities. It is only intended to provide you with an overview. It is important that you also read *The Details — What's Covered and Not Covered* section of this Summary Plan Description and not just rely on this chart for your Benefits coverage information. The Medical Plan uses three networks:

- Enhanced: Your local clinically integrated network (Rainier Health Network)
- In-Network: The Blue Cross Blue Shield National PPO Network
- Out-of-Network: Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate.

A Snapshot of the Medical Plan

	You Pay	You Pay	You Pay
Annual Deductible[1]			
Enhanced: Clinically Integrated Network	$0	$0	$2,700 individual/ $5,400 family
In-Network: BC/BS Network	$1,500 individual/ $3,000 family	$2,500 individual/ $5,000 family	
Out-of-Network	$3,000 individual/ $6,000 family	$6,000 individual/ $12,000 family	$6,000 individual/ $12,000 family
Annual Out-of-Pocket Maximum[2]			
Enhanced: Clinically Integrated Network	$3,000 individual/ $6,000 family	$4,000 individual/ $8,000 family	$4,000 individual/ $8,000 family
In-Network: BC/BS Network	$6,000 individual/ $12,000 family	$6,600 individual/ $13,200 family	$6,450 individual/ $12,900 family
Out-of-Network	$9,000 individual/ $18,000 family	$12,000 individual/ $24,000 family	$12,000 individual/ $24,000 family
Health Savings Account[3] – CHI Funding			
Individual	Not Applicable	Not Applicable	$600
All other coverage levels			$1,200

[1]There are individual Deductibles embedded within the family Deductible. In addition, there is one Deductible that applies to both Enhanced and In-Network

[2]The Out-of-Pocket Maximum includes Prescription Drug Copayments and Coinsurance but does not include penalties or ineligible charges. There are individual Out-of-Pocket Maximums embedded within the family Out-of-Pocket Maximum.

[3]The amount listed is the amount CHI may contribute to your Health Savings Account. You can also contribute on a pre-tax basis. Your contributions and CHI's contribution must not exceed the IRS limits. If you are age 55 or older, you may also contribute an additional $1,000 over the IRS limit.

Summary of Benefits

	Integrated Core Option	Integrated Basic Option	Integrated HDHP/HSA Option
	Plan Pays	**Plan Pays**	**Plan Pays**
Once you satisfy the annual Deductible, the plan will pay the coinsurance percentage listed below until you reach the out-of-pocket maximum. In some circumstances, you are responsible for paying a copayment before the plan will pay the coinsurance.			
Preventive Care Enhanced: Clinically Integrated Network	100%	100%	100%
In-Network: BC/BS Network			
Out-of-Network			
Office Visits*: Primary Care Enhanced: Clinically Integrated Network	100% after $10 Copay	100% after $20 Copay	85% After Deductible
In-Network: BC/BS Network	80% No Deductible	70% No Deductible	80% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Office Visits*: Specialist Enhanced: Clinically Integrated Network	100% after $25 Copay	100% after $35 Copay	80% After Deductible
In-Network: BC/BS Network	75% No Deductible	65% No Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Office Visits: Mental Health Enhanced: Clinically Integrated Network	100% after $10 Copay	100% after $20 Copay	85% After Deductible
In-Network: BC/BS Network	80% No Deductible	70% No Deductible	80% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Urgent Care Enhanced: Clinically Integrated Network	100% after $50 Copay	100% after $75 Copay	100% after $75 Copay After Deductible
In-Network: BC/BS Network	100% after $75 Copay	100% after $100 Copay	100% after $100 Copay After Deductible
Out-of-Network	100% after $75 Copay	100% after $100 Copay	100% after $100 Copay After Deductible
Emergency Room Enhanced: Clinically Integrated Network	100% after $175 Copay, Copay waived if admitted	100% after $200 Copay, Copay waived if admitted	$200 Copay After Deductible, Copay waived if admitted
In-Network: BC/BS Network			
Out-of-Network			
Non-emergency Use of Emergency Room Enhanced: Clinically Integrated Network	50% After Deductible (no Deductible if CHI facility)	50% After Deductible (no Deductible if CHI facility)	50% After Deductible
In-Network: BC/BS Network			
Out-of-Network			

**Related services billed with an office visit are paid at the applicable office visit benefit level. The annual Deductible and applicable coinsurance amount will apply to related services billed separately from the office visit.*
Note: Costs for services received from an Out-of-Network provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges. You may be billed for the difference between the Medicare allowable rate and the provider's billed charges.

Summary of Benefits Continued

	Integrated Core Option	Integrated Basic Option	Integrated HDHP/HSA Option
	Plan Pays	**Plan Pays**	**Plan Pays**
Once you satisfy the annual Deductible, the plan will pay the coinsurance percentage listed below until you reach the out-of-pocket maximum. In some circumstances, you are responsible for paying a copayment before the plan will pay the coinsurance.			
Ambulance* *(air, ground or water) – must be medically necessary* Enhanced: Clinically Integrated Network	100%	100%	100% After Deductible
In-Network: BC/BS Network			
Out-of-Network			
Inpatient Care/Services Enhanced: Clinically Integrated Network	90% No Deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% After Deductible	65% After Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Outpatient Care/Services Enhanced: Clinically Integrated Network	90% (no deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% After Deductible	65% After Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Physical, Speech, Massage & Occupational Therapy *(30 visit maximum for all therapies combined per person per Benefit Year; limit does not apply to Enhanced network.)* Enhanced: Clinically Integrated Network	90% No Deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% After Deductible	65% After Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Durable Medical Equipment Enhanced: Clinically Integrated Network	90% No Deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% After Deductible	65% After Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Inpatient Mental Health and Chemical Dependency Enhanced: Clinically Integrated Network	90% No Deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% No Deductible	65% No Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible

**Most ambulance services are out of network. You may be billed for amounts over the allowed charges.*

Note: Costs for services received from an Out-of-Network provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges. You may be billed for the difference between the Medicare allowable rate and the provider's billed charges.

Summary of Benefits Continued

	Integrated Core Option	Integrated Basic Option	Integrated HDHP/HSA Option
	Plan Pays	**Plan Pays**	**Plan Pays**
Once you satisfy the annual Deductible, the plan will pay the coinsurance percentage listed below until you reach the out-of-pocket maximum. In some circumstances, you are responsible for paying a copayment before the plan will pay the coinsurance.			
Outpatient Mental Health and Chemical Dependency Enhanced: Clinically Integrated Network	90% No Deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% No Deductible	65% No Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Other Covered Services Enhanced: Clinically Integrated Network	90% No Deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% After Deductible	65% After Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Fertility Treatments *($15,000 lifetime maximum per person; $5,000 lifetime maximum on fertility drugs per person)* Enhanced: Clinically Integrated Network	90% No Deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% After Deductible	65% After Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Chiropractic Care *(20 visit maximum per person per Benefit Year)* Enhanced: Clinically Integrated Network	90% No Deductible	85% No Deductible	85% After Deductible
In-Network: BC/BS Network	75% After Deductible	65% After Deductible	75% After Deductible
Out-of-Network	50% After Deductible	40% After Deductible	40% After Deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited

Note: Costs for services received from an Out-of-Network provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges. You may be billed for the difference between the Medicare allowable rate and the provider's billed charges.

Pharmacy Summary of Benefits

Covered prescription expenses will apply toward the medical in-network out-of-pocket maximum. Once the medical out-of-pocket maximum is met, your covered prescriptions will be 100 percent covered by the plan.

	Integrated Core Option		Integrated Basic Option		Integrated HDHP/HSA Option	
	Plan Pays		Plan Pays		Plan Pays	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
CHI-owned Pharmacy (Franciscan Pharmacy), if available (30-Day Prescriptions)						
Generic Drugs	100% after $5 Copayment No Deductible	N/A	100% after $5 Copayment No Deductible	N/A	100% after $5 Copayment and After Deductible	N/A
Brand-name drug on formulary	85% ($20 min/$55 max) No Deductible	N/A	85% ($20 min/$55 max) No Deductible	N/A	85% ($20 min/$55 max) After Deductible	N/A
Brand-name drug not on formulary	75% ($32.50 min/$80 max) No Deductible	N/A	75% ($32.50 min/$80 max) No Deductible	N/A	75% ($32.50 min/$80 max) After Deductible	N/A
CVS/Caremark Retail Pharmacy (30-Day Prescriptions)						
Generic Drugs	100% after $10 Copayment No Deductible	40% No Deductible	100% after $10 Copayment No Deductible	40% No Deductible	100% after $10 Copayment and After Deductible	40% After Deductible
Brand-name drug on formulary	70% ($40 min/$110 max) No Deductible	40% No Deductible	70% ($40 min/$110 max) No Deductible	40% No Deductible	70% ($40 min/$110 max) After Deductible	40% After Deductible
Brand-name drug not on formulary	50% ($65 min/$160 max) No Deductible	40% No Deductible	50% ($65 min/$160 max) No Deductible	40% No Deductible	50% ($65 min/$160 max) After Deductible	40% After Deductible
CHI-owned Mail Order (Franciscan Pharmacy), if available (90-Day Prescription)						
Generic Drugs	100% after $12.50 Copayment No Deductible	N/A	100% after $12.50 Copayment No Deductible	N/A	100% after $12.50 Copayment and After Deductible	N/A
Brand-name drug on formulary	85% ($50 min/$87.50 max) No Deductible	N/A	85% ($50 min/$87.50 max) No Deductible	N/A	85% ($50 min/$87.50 max) After Deductible	N/A
Brand-name drug not on formulary	75% ($80 min/$162.50 max) No Deductible	N/A	75% ($80 min/$162.50 max) No Deductible	N/A	75% ($80 min/$162.50 max) After Deductible	N/A
CVS/Caremark Mail Order (90-Day Prescription)						
Generic Drugs	100% after $25 Copayment No Deductible	N/A	100% after $25 Copayment No Deductible	N/A	100% after $25 Copayment and After Deductible	N/A
Brand-name drug on formulary	70% ($100 min/$175 max) No Deductible	N/A	70% ($100 min/$175 max) No Deductible	N/A	70% ($100 min/$175 max) After Deductible	N/A
Brand-name drug not on formulary	50% ($160 min/$325 max) No Deductible	N/A	50% ($160 min/$325 max) No Deductible	N/A	50% ($160 min/$325 max) After Deductible	N/A

Note: If you fill a brand-name prescription when there is a generic equivalent available, you will pay the brand-name prescription coinsurance ***plus*** the difference between the generic and brand-name

amount. If it is medically necessary for you to have the brand-name prescription, your doctor can contact the CHI prescription administrator to get an exception, so you don't have to pay the difference between the generic and the brand-name amount. You will pay the brand-name cost.

In addition, if you are on a maintenance prescription, such as cholesterol or blood pressure medications, you must use the mail order Pharmacy or a CHI-owned Pharmacy to fill your prescriptions. * If you do not fill your maintenance medication using the CVS/Caremark mail order or CHI-owned Pharmacy, then your prescription will not be covered.

Health Savings Account

If you enroll in the Integrated High Deductible with Health Savings Account (HDHP/HSA) medical plan option, you will be automatically set up with a health savings account (HSA).

The HSA can be used to cover the cost of covered services, including prescription drugs. Or you may choose to pay for these services out-of-pocket and save the money in your HSA for future qualified expenses. You may also use your HSA to cover costs the Plan does not cover, including covered services above the maximum allowable amount, services beyond the annual benefit maximums, coinsurance amounts, and any other qualified medical expenses as determined by the Internal Revenue Service (IRS). Unused dollars in your HSA roll over from year to year.

For the Integrated HDHP/HSA medical plan option, eligible prescription drug expenses apply toward the deductible and out-of-pocket maximum. However, if you use the HSA to pay for IRS-qualified expenses that are not covered by the Medical Plan, those expenses do not count toward your deductible or out-of-pocket maximum. For a listing of qualified medical expenses, refer to Publication 502 on the IRS Web site: www.irs.gov.

Both you and CHI may fund the HSA. CHI may also make a contribution to your HSA for health actions and/or outcomes achieved through the CHI Wellness Program.

You must be an active employee and enrolled in the Integrated HDHP/HSA medical plan option at the time the funding occurs. If you enroll in the Integrated HDHP/HSA plan option after the first month of the year, the amount allocated to your HSA will be prorated. If you experience a change in family status during the Plan year that results in an increase or reduction in coverage level (e.g., going from family to employee only), CHI's contribution amount will change for the remaining pay periods based on the new coverage level.

If you ever become ineligible for any CHI contributions, you must contact CHI at 1-844-450-9450. If you fail to inform CHI of your ineligibility and your account receives any contributions from CHI, those contributions will be subject to the rules and penalties set forth by the IRS.

In addition, you have the option to contribute to your HSA. The amount will be deducted from your paycheck on a pre-tax basis. If you decide to make an after-tax contribution to your HSA, you must work directly with HealthEquity to make the contribution. Your contributions to the HSA are optional. You can make changes throughout the year to your contribution amount. However, it is up to you to manage your contributions, considering any CHI contributions, to ensure your HSA account does not exceed the IRS limits.

The IRS does allow catch-up contributions for employees age 55 or over. An additional $1,000 can be contributed pre-tax throughout the year. You will be notified if the annual catch-up contribution limit changes.

The IRS has regulations regarding enrollment in an HSA:

- You cannot be claimed as a dependent on another individual's tax return;
- You cannot be enrolled in another health plan, such as Medicare; and
- You cannot participate in a health care flexible spending account, including your spouse's flexible spending account. If you enroll in the Integrated HDHP/HSA medical plan option, you may be eligible for the limited health care flexible spending account but no one in your family should be enrolled in a general health care flexible spending account.

If your enrollment in the Integrated HDHP/HSA option ends for any reason, any balance in your HSA is available for you to use for future eligible health care expenses. There may be fees to maintain the account separate from CHI. Contact HealthEquity at 1-866-212-4634 for more information.

Please note that the HSA is administered separately from the medical portion of the Integrated HDHP/HSA option. HealthEquity, Inc administers the HSA feature. You can contact HealthEquity at 1-866-212-4634. Please consult a tax advisor for questions regarding the tax treatment of the HSA.

Quick Reference — What's Covered and Not Covered

Your coverage provides Benefits for many services and supplies. There are also services for which this coverage does not provide Benefits. The following chart is provided for your convenience as a **quick reference only**. This chart is not intended to be and does not constitute a complete description of all Benefits coverage details and factors that determine whether a service is covered or not. All Covered Services are subject to the contract terms and conditions contained throughout this Summary Plan Description. Many of these terms and conditions are contained in *The Details — What's Covered and Not Covered*. To fully understand which services are covered and which services are not, you must become familiar with this entire Summary Plan Description. If you are unsure whether a particular service is covered or not, please contact the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card.

The chart on the following page provides the following information:

Category – Service categories are listed alphabetically and are repeated, with additional detailed information, in *The Details — What's Covered and Not Covered*.

Covered – The listed category is generally covered, but some restrictions may apply.

Not Covered – The listed category is generally not covered.

See page – This column lists the page number in *The Details — What's Covered and Not Covered* where there is further information about the category.

Service/Prescription Maximums and Limitations – This column lists maximum Benefit amounts that each Plan Participant is eligible to receive per Covered Service, prescription, Benefit Plan Year, or a Lifetime Maximum. Service maximums or prescription maximums
that apply per Benefit Year or per Lifetime Maximum are reached from Claim Payment amounts accumulated under this Plan and any prior group health plans sponsored by CHI.

Notification Required – This column indicates categories of care that may require pre-notification of treatment or pre-authorization for the purchase of Prescription Drugs. If there is nothing in this column for a particular type of service, it means that it is not necessary to provide pre-notification of the treatment or obtain pre-authorization to purchase a Prescription Drug.

Quick Reference - What's Covered and Not Covered

Category	Covered	Not Covered	See Page	Maximums and Limitations†	Notification Required‡
Abortions - non-life threatening		Ø	31		
Acupuncture	●		32	10 visits per person per Benefit Year	
Allergy Testing and Treatment	●		32		
Ambulance Transportation	●		32		
Ambulatory Surgical Facilities	●		32		
Anesthesia Services	●		32		
Applied Behavior Analysis (ABA) Therapy			33		
Assistant Surgeons	●		33		
Blood and Blood Administration	●		33		
Cardiac Rehabilitation Services	●		34		
Chemotherapy Treatments	●		34		
Chiropractic Care	●		34	20 visits per person per Benefit Year	
Completion of Claim Forms, Reports, or Medical Records		Ø	34		
Contraceptives	●	Ø	34	Coverage depends on whether you are from a profit or non-profit part of CHI. If not covered through the medical plan, you may have coverage directly through the medical and prescription administrator.	
Cosmetic Surgery - elective		Ø	35		
Cosmetic Surgery - reconstructive	●		35		
Consultations	●		35		
Custodial Care Services		Ø	36		
Cyber Knife Surgery	●		36		
Dental Services - standard		Ø	36		
Dental Services - special circumstances	●		36	Limitations apply	
Diabetes Training Programs	●		37	Twice per lifetime	
Diagnostic Services	●		37		
Digital Breast Tomosynthesis (3D Mammography)	●		37	Benefits based on the following codes only: 77061, 77062, 77063	
Durable Medical Equipment	●		37		
Education or Training Plans		Ø	38		
Emergency Services	●		39		
Eye Examinations - medical Conditions	●		39		
Eye Examinations - vision		Ø	39		
Eyeglasses and cosmetic Contacts		Ø	40		
Eyeglasses or Contacts - after cataract surgery or cornea transplant	●		40	First pair only	

Quick Reference Continued

Category	Covered	Not Covered	See Page	Maximums and Limitations†	Notification Required‡
Fee for Failure to Keep Appointment		Ø	40		
Fees by Family Members		Ø	40		
Fertility Drugs	●		40	Lifetime maximum of $5,000 per person	
Fertility Treatment	●		40	Lifetime maximum $15,000 per covered individual	
Foot Care	●		41		
Foot Orthotics	●		41	Two pairs per Benefit Year	
Genetic Testing	●		41		May be required
Hearing Aids		Ø	41		
Hearing Examinations for Diagnosing Medical Conditions	●		41		
Hearing Examinations for Pure Tone Audiometry Tests		Ø	41		
Home Health Care	●		41		●
Hospice Care	●		42	Life expectancy must be 12 months or less	
Human Organ Transplants	●		44	Cryopreservation and storage $10,000 limit per transplant	●
Inpatient Hospital Care	●		46		●
Kerato-Refractive Eye Surgery		Ø	47		
Leg, Back, and Neck Braces	●		47		
Marriage Counseling	●		47		
Mastectomy and Related Services	●		48		
Maternity Services	●		48		●
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes	●		49		
Mental Health Services - outpatient	●		49		
Mental Health Services - Inpatient	●		49		●
Modifications to Homes, Property, or Automobiles		Ø	50		
Nephropathy screenings	●		50	Covered 100% for diabetic members	
Non-Prescription Drug Medication (except medically necessary B-12 injections)		Ø	51		
Office Visits	●		51		
Outpatient Hospital Care	●		51		
Optometry Services - routine		Ø	53		
Oxygen and its Administration	●		53		

Quick Reference Continued

Category	Covered	Not Covered	See Page	Maximums and Limitations†	Notification Required‡
Personal Hygiene, Comfort, and Convenience Items		Ø	53		
Physicians	●		54		
Pre-Admission Testing	●		55		
Prescription Drugs	●		55		May be required
Prescription Drugs - targeted for step therapy	●		55		●
Preventive or Wellness Care	●		57		
Prosthetic Appliances and Devices	●		57		
Radiation Therapy Treatments	●		58		
Residential Treatment Facilities - Diagnostic tests	●		58		
Residential Treatment Facilities - room and board	●		58		●
Retinal Eye Exams	●		58	Covered 100% for diabetic members	
Routine Physical Exams	●		58		
Shock Therapy Treatments	●		59		
Skilled Nursing Facilities	●		59		●
Smoking/Tobacco Cessation Prescription Drugs	●		59		
Sterilization		Ø	60		
Sterilization Reversals	●		60		
Substance Abuse Rehabilitation Treatment	●		60		●
Surgery	●		61		
Transgender Reassignment Surgery		Ø	61		
Treatment of Temporomandibular Joint Dysfunction and Related Disorders	●		61	Non-surgical treatment of TMJ is not covered by the medical plan but is covered by the dental plan.	
Web Cam Consultations	●		62		
Weight Loss Prescription Drugs		Ø	63		
Weight Loss Surgery	●		62	Limit one per lifetime with allowance for adjustments	●
Wigs or Hair Pieces - if hair loss from medical treatment	●		64	1 wig per year	
X-rays	●		64		

†If nothing is listed in this column, assume there are no limitations or maximums; however, Benefits will not be available if the procedure is not Medically Necessary or not for a Covered Service.
‡If nothing is listed in this column, assume that prior notification is not required.

Adding or Dropping Coverage

This Summary Plan Description (SPD) contains information about the Catholic Health Initiatives Medical Plan for persons who meet the definition of an Eligible Person as determined by Catholic Health Initiatives (CHI) and defined in the *Glossary of Terms* found in the back of this SPD. The *Glossary of Terms* includes the eligibility requirements for you and your Dependents. Please see the definitions of Employee, Spouse, Legally Domiciled Adult and Child.

Please refer to the *Eligibility Addendum* of this SPD for a description of eligibility at each CHI Market-Based Organization (MBO) or facility. If you meet the description of an Eligible Person and have applied for coverage under this Plan, then you are entitled to the Benefits described in this SPD as of your Coverage Date.

Eligibility

Each Employee of an Employer (i.e., CHI and the MBOs listed in the *Eligibility Addendum*) who has satisfied the applicable "regularly scheduled hour" requirement and waiting period listed in the *Eligibility Addendum* (i.e., an Eligible Person) is eligible for coverage under this Plan if such Eligible Person enrolls for coverage and pays any required premium contributions in accordance with applicable procedures established by the Employer. Your coverage under the Plan will end as of the end of the month during which you cease to be an Eligible Person. An Eligible Person may also enroll his or her Dependent(s) for coverage under this Plan in accordance with applicable procedures established by the Employer. Coverage under the Plan for your Dependent(s) will end as of the end of the month during which such Dependent(s) cease to be Dependent(s).

Your Coverage

As an Employee of CHI, you must meet the requirements of your MBO as described in the *Eligibility Addendum* in this SPD.

You may enroll in Individual Coverage or Family Coverage. If you choose to enroll yourself in Individual Coverage, only your own health care expenses, not the health care expenses of your other family members, are covered according to the Benefit levels in this SPD. If you enroll in Family Coverage, your expenses for Covered Services and those of your enrolled Spouse, Legally Domiciled Adult and/or Child(ren) will be covered according to the Benefit levels of this SPD.

Please refer to the definitions of Spouse, Legally Domiciled Adult and Child found in the *Glossary of Terms* section of this SPD to determine who qualifies as a Dependent under this Plan.

Your Dependent's Coverage

Dependents eligible for the Medical Plan include:

- An Eligible Person's Spouse who is legally married to the Eligible Person.
- An Eligible Person's Legally Domiciled Adult who is over age 18 and has, for at least six months, lived in the same principal residence of an employee and remains a member of that employee's household throughout the coverage period; and who either:
  - Has an on-going, exclusive and committed relationship with the employee (not a casual roommate or tenant), shares basic living expenses and is financially interdependent with the

employee, is neither legally married to anyone else nor legally related to the employee by blood in any way that would prohibit marriage.
    - Is the employee's blood adult relative who meets the definition of his or her tax dependent as defined by Section 152 of the Internal Revenue Code during the coverage period and is not considered a Child as defined in this section of the Summary Plan Description.
- An Eligible Person's Child, married or unmarried, by birth, marriage, legal adoption or placement for adoption who is under age 26.
- A Child under age 26, married or unmarried, whom you are required by law to provide health coverage or the Eligible Person is the Legal Guardian, such as a court-approved foster Child.
- A Child under age 26, married or unmarried, of an eligible Legally Domiciled Adult.
- An Eligible Person's unmarried Child by birth, marriage, legal adoption or placement for adoption who is age 26 or older, who is dependent upon the Eligible Person for support and maintenance because of a continuous developmental or physical disability that began prior to the date the dependent attained age 26 and:
    - The disabled dependent was covered by this Plan or other group medical insurance coverage as a disabled dependent prior to reaching age 26.
    - If enrolling for the first time, the disabled dependent who is 26 years of age or older of a newly Eligible Person may be enrolled for coverage if the Eligible Person enrolls during the initial eligibility period and provides proof that the dependent satisfies the foregoing requirements within 31 days of the initial date of eligibility.
    - The Plan may request documentation of the dependent's continued disability on an annual basis. The disabled dependent shall be eligible for coverage so long as the dependent continues to be disabled, unless coverage otherwise terminates under the Plan.
    - The disabled dependent must be continuously covered under the Plan in order to maintain eligibility.

Dependent Eligibility Audit

To be good stewards of our resources and continue to provide affordable, high-quality benefits to employees and their families, CHI verifies the eligibility of our Employees' Dependent(s) enrolled in any of the following plans:

- Medical Plan
- Dental Plan
- Vision Plan

When a Dependent is added to one of these plans, the Employee will receive an audit notice and must return the appropriate documentation by the due date or the Dependent(s) will lose coverage. If the Employee does not respond to the audit or provide appropriate information, the dependent will be dropped from the plan retroactive to the effective date of coverage.

CHI reserves the right to request verification of Dependent status at any time and may pursue any fraudulent activity.

Pre-existing Conditions Waiting Period

The Medical Plan **does not** have a pre-existing Conditions waiting period. You will be entitled to the Benefits described in this Summary Plan Description as of your Coverage Date.

Enrolling in Benefits

Initial Enrollment
You must enroll yourself and your eligible dependents in your benefits within 31 days of the new hire or newly eligible date. If you do not enroll within the initial 31-day enrollment period, you will have to wait until the next Annual Enrollment period to enroll, unless you experience a qualified status change *(see Eligible Reasons and Time Limits to Add Coverage During the Year Due to a Qualified Status Change section).*

Late Enrollment
If you enroll in the Plan within the eligible enrollment timeframe, your benefit elections will remain in effect throughout the year. If you do not meet the enrollment deadline, you won't have coverage (unless you experience a qualified status change or until Annual Enrollment - typically held in the fall).

Enrollment Process

An Eligible Person enrolls in the Medical Plan by completing the enrollment process established for or by the MBO. When enrolling in your coverage you will elect the type of coverage you desire and will indicate which of your eligible Dependents you wish to enroll in the Plan. You must provide the Social Security number of each person enrolling in the medical plan, as required by the Patient Protection and Affordable Care Act.

Type of coverage includes:

- Employee Only
- Employee + Spouse/Legally Domiciled Adult
- Employee + Child(ren)
- Family (includes either a Spouse or Legally Domiciled Adult, and Children)

Your Cost of Coverage

If elected, you and CHI share in the cost of medical/prescription drug coverage. Your contributions will be deducted from your paycheck on a before-tax basis.

Eligible Reasons and Time Limits to Add Coverage During the Year Due to a Qualified Status Change

You should enroll as soon as possible, but enrollment must be completed within the following time limits:

- The initial enrollment must be completed within the initial 31-day enrollment period.
- If you have a new Dependent as a result of a birth, adoption, obtaining Legal Guardianship, or interim court order prior to finalization of adoption, you can enroll your Dependent within 60 days of that Qualified Status Change.
- If you have a new Dependent as a result of a marriage, you can enroll your Dependent within 31 days of that Qualified Status Change.
- If you declined enrollment for yourself and/or your Dependents because of other health insurance coverage, you can enroll yourself and/or your Dependents during the year if you and/or your Dependents lose eligibility for that coverage. You must request enrollment for yourself or a Dependent within 31 calendar days after your other coverage ends.

- If you declined enrollment for yourself and/or your Dependents because of other health insurance coverage and another Employer stops contributing to that coverage, you can enroll yourself and/or your Dependents during the year. However, you must request enrollment for yourself or a Dependent within 31 calendar days after the other Employer stops contributing toward the other coverage.
- An Eligible Person or Dependent may also enroll in the Plan within 31 days of a life event or Qualified Status Change, such as marriage, if such enrollment is necessary, as a result of, and consistent with the change in status.
- If you and/or your Dependent either lose eligibility for a Medicaid or state Child Health Insurance Program (state CHIP), or gain eligibility for Medicaid or state CHIP premium assistance program that pays part of the cost of coverage for you and/or your Child, you must enroll you and/or your Child within 60 days of the date of eligibility or loss of coverage under the government program.

If you add a Dependent as a result of a Qualified Status Change, the coverage will be retroactive to the date of the Qualified Status Change, and you will be responsible for any back premiums incurred as a result of the change.

All charges for the newborn inpatient stay (both facility and professional charges) while the mother is in the hospital (or beyond the mother's discharge date) will not be covered under the Plan until the newborn Child is added to the Plan. You must enroll the Child in the Plan within 60 days of the date of birth. If the newborn Child is not added within 60 days, the Child will not be eligible for coverage until the next Annual Enrollment, even if you already have Family Coverage. The Child must meet the definition of a Dependent as defined in the *Glossary of Terms* in this SPD in order to be enrolled in this Plan.

You must wait until the next Annual Enrollment period to enroll the Eligible Person. Annual Enrollment periods will be conducted prior to the beginning of each Benefit Year.

Time Limits for Changing or Dropping Your Coverage Due to a Qualified Status Change or Life Event

- If an enrolled Dependent loses his or her eligibility as a Dependent for any reason, including but not limited to a divorce, legal separation, annulment, ceasing to be within the age limits or the death of a Dependent, you must remove that Dependent within 31 days of the Qualified Status Change or within 31 days of the date coverage is to terminate, whichever is later.
- If you or an enrolled Dependent becomes eligible for coverage under another Plan, you may drop this coverage within 31 days of becoming eligible for that plan.
- If you or an enrolled Dependent enroll in a medical plan option available through the Exchange, you may drop this coverage within 31 days of enrolling in the Exchange.
- If you or your Dependent Child become eligible for coverage under Medicaid or state CHIP, you may drop this coverage within 60 days of becoming eligible for Medicaid or state CHIP.

If you terminate coverage for yourself or an enrolled Dependent as a result of a Qualified Status Change, the coverage will be terminated at the end of the month in which the Qualified Status Change took place. Premiums will cease as of the end of the month in which coverage terminates. In no instance will the Plan be obligated to pay a Claim for an ineligible Person, even if you are paying a higher premium because the Dependent was not dropped within the proper time frame or was covered but was not eligible for such coverage.

Qualifying Events for Changing Your Coverage:

Change in legal marital status
Must notify Plan within 31 days

- Marriage (Spouse becomes eligible for this Plan)
- Divorce (Spouse is no longer eligible for coverage under this Plan)
- Legal Separation (Spouse is no longer eligible for coverage under this Plan)
- Annulment (Spouse is no longer eligible for coverage under this Plan)
- Death of a Spouse

Change in number of dependents
Must notify Plan within 60 days

- Birth
- Adoption
- Obtaining legal custody of a child
- Child gains or loses eligibility for Medicaid or state Children's Health Insurance Program (CHIP)
- Must notify Plan within 31 days
- Marriage resulting in gaining step-children
- Obtaining legal guardianship or court approved foster care of a child
- Child age 26 or over is approved for continuous coverage due to a continuous developmental or physical disability that began while the child was covered under this Plan or other group medical insurance coverage (coverage must be continuous since the inception of the child's disability)
- A Qualified Medical Child Support Order (QMCSO) goes into effect
- Death
- Placement for adoption
- Divorce resulting in loss of step-children
- Losing legal guardianship or court approved foster care of a child
- Losing legal custody of a child
- A child reaches the maximum age under the Plan
- A Qualified Medical Child Support Order (QMCSO) is terminated

Change in Employment Status of you or your Spouse
Must notify Plan within 31 days

- Termination of employment
- Gaining employment
- Strike or lockout
- Beginning an unpaid leave of absence
- Ending an unpaid leave of absence
- Change in worksite that results in different plan options
- Change in employment status affecting eligibility for Benefits

Other qualifying events
Must notify Plan within 31 days

- Group plan you were enrolled in or were eligible for through another employer or group has a material and substantive change making it significantly more or less attractive to you
- The group plan you or your eligible dependents were enrolled in was terminated
- Gaining or losing eligibility for Medicare or COBRA
- Your Legally Domiciled Adult who was not eligible before becomes eligible under the eligibility affidavit guidelines.
- Your enrolled Legally Domiciled Adult no longer meets the eligibility criteria listed in the eligibility affidavit.

Consistency Rule

An election change must be due to and consistent with the Qualified Status Change that affects eligibility for coverage under this plan.

For example, you would not be permitted to add a Child from your prior marriage who was not previously covered under this Plan just because you re-married. However, you would be permitted to add your new Spouse and step-Children as a result of that marriage if you enroll them within 31 days of the date of your marriage.

Qualified Medical Child Support Orders

The term "qualified medical child support order" means a qualified medical child support order within the meaning of ERISA Section 609 which is a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under the Plan provided that such medical support order clearly specifies:

- The name and last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such alternate recipient,
- A reasonable description of the type of coverage to be provided to each such alternate recipient, or in the manner in which such type of coverage is to be determined, and
- The period to which such order applies and does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act [42 USC § 1396g] (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993). The term "medical child support order" means any judgment, decree, or order (including approval of a settlement agreement) which
  - Provides for child support with respect to a child of a participant under this Plan, and provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under this Plan; or
  - Is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act [42 USC § 1396g] (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan, if such judgment, decree, or order is issued by a court of competent jurisdiction or is issued through an administrative process established under state law and has the force and effect of law under applicable state law. For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in the preceding sentence and which has the effect of a court order shall be treated as such an order.

The term "alternate recipient" means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

Dual Coverage Under This Plan is Prohibited

No person will be covered as a Dependent of more than one Employee, and no person will be covered as both an Employee and a Dependent.

Changes in the Employment Status of You or Your Spouse/Legally Domiciled Adult That Will Affect Your Enrollment in This Plan

If you become eligible for this Plan as a result of a change in Employment Status, you may enroll in this Plan within 31 days of your change in Employment Status.

If you lose eligibility for this Plan, your coverage will automatically be terminated at the end of the month in which you become ineligible for this coverage due to a change in your Employment Status.

If you or your Dependents enroll in coverage because your Spouse/Legally Domiciled Adult loses eligibility for coverage through his or her Employer due to a change in Employment Status, you and your Dependents may enroll in this Plan within 31 days of the date that your Spouse/Legally Domiciled Adult loses coverage through his or her Employer. However, coverage through the other plan must not have been terminated for failure to pay premiums or for fraudulent cause.

If you or your Dependents drop coverage because your Spouse/Legally Domiciled Adult enrolls in coverage through his or her Employer due to a change in Employment Status, you and your Dependents may drop this Plan within 31 days of the date that your Spouse/Legally Domiciled Adult enrolls in coverage through his or her Employer.

Your ID Card

After enrolling in the Plan, you will receive a Medical Plan ID Card. This card includes your member identification number and will be very important to you in obtaining Benefits for Medical Care and Prescription Drugs. You will receive one ID card if you have Single Coverage and you will receive two ID cards if you have Family Coverage. Both ID cards will show your name. If you need additional ID cards, please call the CHI Medical Plan Customer Service Team at the number on the back of your ID card to request them.

Medicare Eligible Persons and Their Enrollment in This Plan

If you meet the definition of an Eligible Person found in the *Glossary of Terms* section of this Summary Plan Description, and you are eligible for Medicare, and not affected by the Medicare Secondary Payer (MSP) laws as described below, the Benefits described in the section of this Summary Plan Description entitled *Benefits for Medicare Eligible Persons* will apply to you and your Spouse and covered Dependent Children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the "Medicare Secondary Payer" (MSP) laws regulate the manner in which certain Employees may offer group health care coverage to Medicare eligible Employees, Spouses, and in some cases, Dependent Children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and the Medical Plan coverage, as well as certain other factors, including the size of the Employers sponsoring the group health plan. In general, Medicare pays secondary (after the Medical Plan makes its payment) to the following:

- The Medical Plan that covers individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of whether the individual has "current Employee status."

- In the case of individuals age 65 or over who still meet the definition of an Eligible Person.
- In the case of disabled individuals under age 65, if the individual or a member of the individual's family has "current Employee status."

Please Note: Call the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card should you have any questions regarding the ESRD primary period or other provisions of MSP laws and their application to you, your Spouse, or any Dependents.

Your Medicare Secondary Payer (MSP) Responsibilities

In order to assist CHI in complying with Medicare Secondary Payer (MSP) laws, it is very important that you promptly and accurately complete any requests for information from the Claims Administrator and/or CHI regarding the Medicare eligibility of you, your Spouse, and covered Dependent Children. This includes any requests for your Dependents' Social Security number. MSP laws **require** Claims Administrators to report the Social Security number of Dependents covered under this Plan who are eligible for Medicare. Failure to provide a requested Social Security number will result in the suspension of Claims payments by this Plan. Therefore, you are encouraged to provide your Dependents' Social Security numbers when enrolling them in the Plan.

If you, your Spouse/Legally Domiciled Adult, or covered Dependent Child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please promptly contact the CHI Customer Service Team at the toll-free number listed on the back of your ID card to ensure that your Claims are processed in accordance with applicable MSP laws.

What You Pay — A Tutorial

This tutorial explains how the Plan pays for **Covered Services and Supplies**. Please keep in mind that not all services received will be covered under this Plan. You will pay the **full cost** for any services and supplies that are **not** covered under this Plan. Please refer to the sections of this Summary Plan Description titled *The Details — What's Covered and Not Covered* and *General Conditions of Coverage, Exclusions, and Limitations* for more information regarding what is covered and what is not covered by this Plan.

The Medical Plan uses three networks:

- Enhanced: Your local clinically integrated network (Rainier Health)
- In-Network: The Blue Cross Blue Shield National PPO Network
- Out-of-Network: Out-of-Network providers

You will not be responsible for any amounts over the Eligible Charges for Enhanced or In-Network charges. However, you will be responsible for your Out-of-Network Deductible, Coinsurance, and any additional amounts if you choose to go to an Out-of-Network Provider. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges.

Payments for CHI Facilities

For purposes of this document, local Catholic Health Initiatives (CHI) Facilities may be considered part of the Enhanced network. You may receive an enhanced Benefit if you receive services from a CHI facility within the Enhanced network.

Under the Integrated Core and Integrated Basic options, the Deductible will not be applied to facility charges billed on the Universal Billing (UB) form received within the Enhanced network. The Deductible does apply to Physician charges.

Under the Integrated HDHP/HSA option, only Preventive Care services can be reimbursed under this option until your Deductible is met, even if you use a CHI facility.

How the Plan Pays for Office Visits

For office visits, if you see a provider within the Enhanced network, you will pay a flat Copayment for your office visit. If you see an In-Network Provider, the Billed Amount by the Physician will be reduced to the negotiated Eligible Charge. This negotiated eligible Charge often reflects a discount that the Physician has agreed to accept from the Medical Plan Administrator. The Plan will pay the appropriate Coinsurance percentage shown in the *Highlights of the Medical Plan Options* section of this SPD for the option you elected. Under the Integrated Core and Integrated Basic options, the Deductible will **not** be applied to office visit charges. Under the Integrated HDHP/HSA option, you must meet the Deductible before the plan begins to pay.

These payments count toward the In-Network and Out-of-Network Out-of-Pocket Maximums.

An office visit includes the office visit and any services bundled with the office visit claim (meaning services performed by the provider; at the provider's office and during the office visit). Any services that are provided or billed by a different provider or at a different location (such as laboratory services, x-rays, office procedures or other ancillary charges) are still covered under the Plan but will be subject to the applicable Deductible and Coinsurance. For example, when blood is drawn during your office visit and the blood work is processed and billed by your physician, the charges would be bundled with the office visit claim and are subject to the applicable office visit Coinsurance. However, if that blood work is sent to a third party for analysis, the charges for the analysis do not fall under the office visit but would be subject to the applicable Deductible and Coinsurance.

How Does the Plan Pay for Office Visits for In-Network Providers?

This example illustrates how office visits are paid for In-Network Providers. Figures used are for illustration purposes and are not intended to reflect typical charges for a service. Only the office visit and services bundled with the office visit claim (meaning services performed by the provider, at the provider's office and during the office visit) will be subject to the office visit coinsurance and will not be subject to the Deductible. Any services that are provided or billed by a different provider or at a different location will be subject to applicable Deductible and Coinsurance.

This example is for services that are not preventive in nature. Mary's diagnosis is influenza.

Service Provided	Billed Amount	Eligible Charges	You Pay		
			Integrated Core	**Integrated Basic**	**Integrated HDHP/HSA**
Primary Care Coinsurance			20%	30%	20% after deductible
Office Visit	$180.00	$90.00	$18.00	$27.00	$90.00
Blood draw and analysis* (at provider's office performed by and billed by the provider)	$25.00	$15.00	$3.00	$4.50	$15.00
Total	$205.00	$105.00	**$21.00**	**$31.50**	**$105.00** – Keep in mind you may have funds in your health savings account to pay for this.

** If blood work (including the draw and/or the analysis) is billed separately by an outside lab, the lab charges will be subject to the deductible and paid at the outpatient coinsurance percentage.*

An Out-of-Network Provider may bill for the difference between the billed amount and the Medicare allowed amount, and you would be responsible to pay that bill since the Out-of-Network provider does not have a contract with the Plan Administrator. Some Out-of-Network Providers may decide to waive this amount, but the Provider is not required to do so. Services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges.

How Does the Plan Pay for Office Visits for Out-of-Network Providers?

This example illustrates how office visits are paid for Out-of-Network Providers. Figures used are for illustration purposes and are not intended to reflect typical charges for a service. Office visit services provided to Jane by an Out-of-Network provider are subject to the Deductible.

This example assumes that Jane's Deductible has been met and that none of the services received are preventive in nature. It does not account for the Health Savings Account funds. Jane's diagnosis is influenza.

Service Provided	Billed Amount‡	Eligible Charges	You Pay		
			Integrated Core	**Integrated Basic**	**Integrated HDHP/HSA**
Primary Care Coinsurance			50% after deductible	60% after deductible	60% after deductible
Office Visit	$180.00	$60.00	$30.00	$36.00	$36.00
Blood draw and analysis† (at provider's office performed by and billed by the provider)	$25.00	$15.00	$7.50	$9.00	$9.00
Total	$205.00	$75.00	**$37.50**	**$45.00**	**$45.00**
Difference between billed amount and Maximum Allowed Amount*			$130.00	$130.00	$130.00

** An Out-of-Network Provider may also bill for the difference between the billed amount and the negotiated amount, and you would be responsible to pay that bill since the Out-of-Network provider does not have a contract with the Plan Administrator. Some Out-of-Network Providers may decide to waive this amount, but the Provider is not required to do so. Services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges.*
† If blood work (including the draw and/or the analysis) is billed separately by an outside lab, the lab charges will be subject to the deductible and paid at the out-patient coinsurance percentage.

How the Plan Pays for Preventive Care

For all Plan options, routine physical exams, well-woman exams (includes Pap smear), routine mammograms, routine pediatric exams, immunizations and other preventive services will be covered at 100 percent of the Eligible Charge. The Deductible will not be applied.

How the Plan Pays for Urgent Care Visits

There is a Copayment whenever you visit an urgent care. Please refer to the *Highlights of the Medical Plan Options* section of this SPD to find the appropriate urgent care Copayment for the option you elected. Under the Integrated Core and Integrated Basic options, this Copayment is **not** subject to the Deductible. Under the Integrated HDHP/HSA option, you must meet the Deductible before the plan begins to pay.

How the Plan Pays for Emergency Room Visits

There is a Copayment whenever you visit an Emergency room for an Emergency or Medically Urgent Situation. Please refer to the *Highlights of the Medical Plan Options* section of this SPD to find the appropriate Emergency Room Copayment for the option you elected. Under the Integrated Core and Integrated Basic options, this Copayment is **not** subject to the Deductible. Under the Integrated HDHP/HSA option, you must meet the Deductible before the plan begins to pay. If you are admitted to the Hospital, the Copayment is waived. For Emergency room visit purposes, Out-of-Network Providers will be treated the same as In-Network Providers.

If your visit to the Emergency room is for a non-Emergency, the Eligible Charge (In-Network Providers) will be subject to the Deductible and the remainder of the charge/fee will be paid based on the *Highlights of the Medical Plan Options*.

How to Save Money When Purchasing Prescription Drugs

The amount you pay for a Prescription Drug depends upon whether you purchase a Generic Drug, a Formulary Drug, or a non-Formulary Drug. You will save money if you purchase Generic Drugs, when available. The amount you pay also depends upon whether you purchase the drug through a CHI-owned Pharmacy (if available), an in-network retail Pharmacy or the mail-order program. You will save 50 percent off your copay/coinsurance cost if you are able to fill a 30 or 90-day prescription at a CHI-owned Pharmacy. Go to the *well-being* pages found on InsideCHI at **http://home.catholichealth.net/wellbeing** or call the HR/Payroll Connection Support Center at 1-844-450-9450 for a list of CHI-owned pharmacies (if available). You can also save money if you use the mail-order program to purchase maintenance drugs. You can receive up to a 90-day supply of your medication and save money on your Copayment or Coinsurance amount, while experiencing the convenience of having your prescriptions mailed directly to your home address.

If the Pharmacy's charge is less than the Copayment or Coinsurance minimum amount, you pay the Pharmacy's charge for that drug. Please refer to the *Highlights of the Medical Plan Options* chart in this SPD for the Copayment and Coinsurance amounts for the option that you elected.

How the Deductible Works

You must meet a calendar year Deductible before this Plan pays Benefits for many Covered Services and Supplies. Please refer to the *Highlights of the Medical Plan Options* chart

for information on services that are not subject to the calendar year Deductible (e.g., CHI Facility charges, Emergency room visits for Emergencies or Medically Urgent Situations, Preventive Care Services). The calendar year Deductible applies each January 1 to December 31.

Under the Integrated HDHP/HSA option, the Enhanced and In-Network deductibles are combined. Copayments, such as the Emergency Room Copayment, office visit charges, charges for services performed in a CHI facility and billed as a facility charge and Prescription Drug charges do not apply to your Deductible under the Integrated Core and Integrated Basic plans. Penalties, such as pre-notification penalties, also do not apply to your Deductible. Please refer to the *Highlights of the Medical Plan Options* and *The Details — What's Covered and Not Covered* sections of this SPD to determine which services are subject to the Deductible.

If you have Individual Coverage, the Plan begins paying a percentage of your Eligible Charges after you meet your Individual Deductible for the remainder of the calendar year. Your Individual Deductible can be found on the *Highlights of the Medical Plan Options* under the option in which you enrolled.

The family Deductible works differently. If you have Family Coverage, you can meet your Deductible in one of two ways:

- An enrolled family member can meet the individual Deductible; or
- All family members can combine their Deductible expenses to meet the family Deductible.

Once your family Deductible is met, this Plan begins paying a percentage of your Eligible Charges for you and all of your enrolled Dependents for the remainder of the calendar year.
If one enrolled family member meets the individual Deductible the Plan begins paying a percentage of his or her Eligible Charges for the remainder of the calendar year. That family member's expenses that were applied toward his or her individual Deductible will also count toward the family Deductible.

How Does the Family Deductible Work?

This example illustrates how the family Deductible works. Figures used are for illustration purposes and are not intended to reflect typical charges for a service.

Example #1:

- This example does not account for the Health Savings Account funds.
- Jane has Family Coverage for herself, her husband and her two kids.
- All care is from In-Network Providers.
- None of the charges are for Emergency room services.

For this example, we're only going to look at Jane's expenses:

Procedure	Eligible Charges	Amount Toward Deductible		
		Integrated Core	**Integrated Basic**	**Integrated HDHP/HSA**
Preventive Office Visit	$200.00*	$0*	$0*	$0*
Outpatient Lab	$85.00	$85.00	$85.00	$85.00
Outpatient X-ray	$125.00	$125.00	$125.00	$125.00
20 Physical therapy visits	$600.00	$600.00	$600.00	$600.00
Outpatient Surgery	$1,500.00	$892.50‡	$1,500.00	$1,500.00
Outpatient Lab	$250.00	$62.50‡	$211.00‡	$250.00
Follow-up X-ray	$125.00	$31.25‡	$43.75‡	$125.00
Total		**$1,796.25** ($1,500 Individual Deductible has been met; remaining $296.25 is applicable Coinsurance)	**$2,564.75** ($2,500 Individual Deductible has been met; remaining $64.75 is applicable Coinsurance)	**$2,685.00** ($2,700 Individual Deductible has not been met) **

**Total amount paid as preventive service. Deductible does not apply.*
*** As a reminder, each plan has a family Deductible. Individual Deductibles are combined to meet the family Deductible.*
‡Deductible has been satisfied. Balance of Eligible Charge will be paid at applicable Coinsurance percentage.

Example #2:

- This example does not account for the Health Savings Account funds.
- Jane has Family Coverage for herself, her husband and her two kids.
- All care is from In-Network Providers.
- None of the charges are for Emergency room services.
- For simplicity, assume Jane's expenses were all incurred first; her husband's expenses were incurred next; her son's expenses next; and her daughter's expenses were incurred last.

Each family member has the following Eligible Charges:

Family Member	Eligible Charges	Amount Toward Deductible		
		Integrated Core	**Integrated Basic**	**Integrated HDHP/HSA**
Jane's Expenses	$400.00	$400	$400	$400
Husband's Expenses	$1,700.00	$1,550*	$1,700	$1,700
Son's Expenses	$1,200.00	$1,125‡	$1,200	$1,200
Daughter's Expenses	$800.00	$200‡	$800	$800
Total		**$3,275** ($3,000 Family Deductible has been met; remaining $275 is applicable Coinsurance)	**$4,100** ($5,000 Family Deductible hasn't been met)	**$4,100** ($5,400 Family Deductible hasn't been met)

**In- Network individual Deductible is met. Balance of Eligible Charge will be paid at applicable Coinsurance percentage.*
‡ In-Network family Deductible is met. Balance of Eligible Charge will be paid at applicable Coinsurance percentage.

How Copayments Work

A Copayment is a specific dollar amount that you are asked to pay in order to receive a Covered Service or Supply. Examples of Copayments are the Emergency Room Copayment, Urgent Care Copayment and the Copayment when you are purchasing Generic Drugs. Under the Integrated HDHP/HSA option, you are still responsible for meeting the Deductible even for services with a Copayment. Copayments under all the plan options are applied to your Out-of-Pocket Maximums.

How Coinsurance Works

Coinsurance is a percentage of the Eligible Charge. The Plan pays a percentage of those charges and you also pay a percentage of the charges. Many services that have a Coinsurance amount are first subject to the Deductible. Exceptions are the Coinsurance amounts under the Integrated Core and Integrated Basic options for office visits, services billed as Enhanced network charges, and charges for Prescription Drugs, since these services are not subject to the Deductible. The chart in the *Highlights of the Medical Plan Options* section of this SPD shows the Coinsurance amount that the Plan pays for each of the medical Plan options available.

The Coinsurance amount that you pay will be the difference between the Coinsurance amount that the Plan pays and 100 percent of the Eligible Charge.

How the Out-of-Pocket Maximum Works

The plan limits the amount of money you have to pay out-of-pocket each year for covered services. This is your annual out-of-pocket maximum. Coinsurance amounts, copayment amounts and any expenses you pay toward your deductible apply toward your out-of-pocket maximum. The amount you spend toward covered prescription drugs will also apply toward your annual out-of-pocket maximum. Once you reach the out-of-pocket limit, the plans pay 100 percent of your covered expenses for the remainder of the year. The out-of-pocket maximum amount is different for each medical plan option — refer to the *Highlights of the Medical Plan Options* section for details.

Note: There are individual out-of-pocket maximums inserted (embedded) within the family out-of-pocket maximum, so no family member would go over their individual out-of-pocket maximum.

There Are Three Different Levels of Benefits

There are three different Benefit levels. The level of Benefits that you receive depends on whether your care is provided by an Enhanced Provider (CHI Facility or your local Clinically Integrated Network Provider), an In-Network Provider (Blue Cross Blue Shield Network Provider), or an Out-of-Network Provider. The highest level of Benefits will be paid for Enhanced Facility and Provider Charges. The next highest level of Benefits will be paid for Eligible Charges incurred for Covered Services and Supplies provided by an In-Network Provider. The lowest level of Benefits will be paid for Eligible Charges incurred for Covered Services and Supplies provided by an Out-of-Network Provider.

Please keep in mind that you will receive the In-Network level of Benefits for services provided by an In-Network Provider, even when an Enhanced CHI Facility or local Clinically Integrated Network Provider is unavailable, unable, or unqualified to perform the services required. In no instance will an In-Network Provider ever be reimbursed at the Enhanced network rate. There will be **no exceptions** made.

With few exceptions, you will receive Benefits at the Out-of-Network level of Benefits if services are provided by an Out-of-Network Provider. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services.

However, if an In-Network Provider that is qualified to perform a particular service is not available within a 50-mile radius of your home address, Benefits will be paid at the In-Network Provider level of Benefits. Please seek pre-approval from the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card if you believe there is no In-Network Provider available and are seeking an exception to use an Out-of-Network Provider to be paid at the In-Network Provider level of Benefits. See the *Network Details — Choosing a Provider* section of this SPD.

The Details — What's Covered and Not Covered

Benefits described in this section will be provided only when you receive services on or after your Coverage Date and the services must be **Medically Necessary**. All Covered Services and Supplies listed in this section are subject to the *General Conditions of Coverage, Exclusions, and Limitations* section of this Summary Plan Description (SPD). If a service or supply is not specifically listed, do **not** assume that it is a Covered Service. Benefits are typically **not** provided for services or supplies that are not specifically mentioned in this SPD.

If you are in doubt about a particular service being covered, or if you have any questions regarding the extent of coverage for a particular service or supply, please contact the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID Card.

For coverage levels, please refer to the *Highlights of the Medical Plan Options* section of this SPD for the Plan option that you elected. Please refer to the *Glossary of Terms* section of this SPD for the definitions of terms that are capitalized. Please refer to the *Medical and Pharmacy Notification Requirements and Care Coordination* section of this SPD to find out which services require pre-notification for medical claims or Prior Authorization for Prescription Drug claims.

The *Quick Reference — What's Covered and Not Covered* section of this SPD may be used for a quick overview; however, please do **not** depend solely on that section of this SPD to obtain all of your Benefits information, as the exclusive use of that section might result in unanticipated out-of-pocket expenses.

The Benefits provided and the expenses that are your responsibility for the Covered Services will depend on whether you use an In-Network or Out-of-Network Provider. For purposes of this section, all Catholic Health Initiatives (CHI) Facilities are covered at a richer enhanced facility Benefit and are not subject to the Deductible.

Services and supplies are listed in alphabetical order, and both Covered Services and Supplies and non-Covered Services and Supplies are listed within this section. If there is a "See Also" notation after a particular heading, please be sure to refer to the section(s) indicated to attain a complete picture of the covered Benefits, the Benefit limitations, and any exclusions. Remember, whenever the terms "you" and "your" are used, we also mean all eligible and enrolled Dependents.

Abortions

Covered:
Abortions are covered in a life-threatening situation where intervention is required.

Not Covered:
Benefits will not be provided for elective abortions except as stated above.

See Also:
Contraceptives and Contraceptive Devices later in this section.
Sterilization Procedures later in this section.

Acupuncture

Covered:
Benefits will be provided for Acupuncture when these services are rendered by a Physician or licensed Acupuncturist. Your Benefits for Acupuncture will be limited to a maximum of 10 visits per Benefit Year. This is a combined maximum for services rendered by an In-Network Provider, and/or an Out-of-Network Provider.

Not Covered:
Benefits will not be provided for Acupuncture services that are not rendered by a Physician or licensed Acupuncturist.

Allergy Testing and Treatment

Covered:
Benefits for allergy testing and treatment are covered 100 percent. Benefits for allergy testing and treatment are subject to the Deductible under the Integrated HDHP/HSA option.

Ambulance Transportation

Covered:
Benefits will be provided for Medically Necessary Ambulance Transportation from your home, or the scene of Accident, Emergency, or Medically Urgent Situation to a Hospital, between Hospitals, between a Hospital and a Skilled Nursing Facility, or from a Hospital or Skilled Nursing Facility to your home.

Costs for services received from an Out-of-Network provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges. You may be billed for the difference between the Medicare allowable rate and the provider's billed charges.

Not Covered:
Benefits will not be provided for long distance trips or for use of an Ambulance because it is more convenient than other transportation.

See Also:
Inpatient Hospital Care later in this section.
Home Health Care later in this section.
Human Organ Transplants later in this section.
Skilled Nursing Facilities later in this section.
Transportation and Lodging later in this section.

Ambulatory Surgical Facilities

Covered:
Ambulatory Surgical Facilities are covered under the outpatient level of Benefits.

Anesthesia Services

Covered:
Anesthesia Services and the administration of anesthesia by a Covered Provider are covered if administered at the same time as a covered surgical procedure in a Hospital, Ambulatory Surgical

Facility, or surgeon's office. Benefits will also be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility, if such services are also covered under this Plan.

Not Covered:
Benefits will not be provided for anesthesia used during surgical procedures, such as cosmetic procedures, that are not covered under this Plan. Additionally, local or topical anesthesia billed separately from related surgical or medical procedures are not covered.

See Also:
Acupuncture earlier in this section.
Cosmetic Surgery later in this section.
"-ologists" at In-Network and CHI Facilities later in this section.
Surgery later in this section.

Applied Behavior Analysis (ABA) Therapy

Covered:
Benefits will be provided for ABA therapy. The Mental Health Services benefit will apply for this type of service.

Assistant Surgeons

Covered:
Benefits will be provided for a Physician, Dentist, Podiatrist, or Registered Surgical Assistant who assists the operating surgeon in performing covered Surgery.

Not Covered:
Benefits will not be provided for assistant Surgery services that are not determined to be Medically Necessary or that are for surgical procedures that are not covered under this Plan.

See Also:
Eligible Charges for Multiple Surgical Procedures later in this section.
Surgery later in this section.

Blood and Blood Administration

Covered:
Blood and blood administration, including blood derivatives and blood components are covered under this Plan.

Not covered:
Benefits are not provided for any service that is considered Investigational as it relates to a particular Illness.

See Also:
Surgery later in this section.

Cardiac Rehabilitation Services

Covered:
Your Benefits for cardiac rehabilitation services are covered if they are Medically Necessary. Medically supervised Cardiac rehabilitation (CR) programs may be considered Medically Necessary for patients with a history of the following Conditions and/or procedures:

- Acute myocardial infarction (MI) also known as heart attack;
- Coronary artery bypass graft (CABG) Surgery;
- Percutaneous transluminal coronary angioplasty (PTCA);
- Heart Valve Surgery;
- Heart transplantation;
- Stable Angina pectoris;
- Congestive heart failure; and
- Transmyocardial revascularization.

A cardiac rehabilitation treatment plan may be considered Medically Necessary for three sessions per week for up to a 12-week period (36 sessions). Programs are to start within 90 days of the cardiac event and be completed within six months of the cardiac event.

Chemotherapy Treatments

Covered:
The use of chemical agents to treat or control a serious Illness is covered.

Not Covered:
Benefits will not be provided for any service that is considered Investigational as it relates to a particular Illness.

See Also:
Cyber Knife Surgery later in this section.
Radiation Therapy Treatments later in this section.
Wigs or Hair Pieces later in this section.

Chiropractic Care

Covered:
Benefits will be provided for muscle manipulations (chiropractic care). Muscle manipulations must be performed by a licensed Chiropractor, Physician, or licensed Massage Therapist. Chiropractic care is limited to a Benefit Year maximum of 20 visits per covered individual for both In-Network and Out-of-Network Providers combined.

Completion of Claim Forms, Reports, or Medical Records

Not Covered:
Benefits are not provided for charges to complete Claim forms, reports, or medical records.

Contraceptives and Contraceptive Devices

Covered:
If you work for a for-profit CHI market*, the following FDA-approved preventive contraception services and prescriptions are covered through the Medical Plan:

- Medical: Patient education and counseling on contraceptives, administration of certain contraceptives (such as the insertion of IUD's or injections) and women's sterilization procedures.
- Prescription drugs: Generic contraceptives, over-the-counter contraceptives with a prescription, and multi-source brand contraceptives (when a doctor determines it medically necessary).

If you work for a non-profit CHI market, you will need to work directly with your medical and prescription plan administrator to receive preventive coverage for the services listed above at 100 percent. Our non-profit business lines fall under a religious exemption to the contraceptive mandate and therefore the Medical Plan does not cover these services.

**For- profit CHI markets include: Center for Translational Research, Harrison Medical Center, St. Joseph's Regional Services, Mountain Management, Mercy Services Corp., CHI Health Partners.*

Not Covered:
If you work for a non-profit CHI market, benefits will not be provided for contraceptives (oral or non-oral dosage forms) and contraceptive devices used to prevent conception, even if deemed Medically Necessary. You will need to work directly with your medical and prescription plan administrator to receive preventive contraceptive coverage.

See Also:
Sterilization Procedures later in this section.

Cosmetic Surgery

Covered:
Reconstructive Surgery following a mastectomy or when Medically Necessary to correct damage caused by an Accident, an Accidental Injury, or to correct a congenital defect.

Not Covered:
Benefits will not be provided for cosmetic Surgery and related services and supplies except as stated above.

See Also:
Surgery later in this section.

Consultations

Covered:
Benefits for consultations when you are in Inpatient in a Hospital or Skilled Nursing Facility are covered. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a Condition which requires special skill or knowledge.

Not Covered:
Benefits will not be provided for a consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same Admission.

Benefits also will not be provided for telephone consultations or providing information concerning a Claim.

Custodial Care Services

Not Covered:
Benefits will not be provided for Custodial Care Services.

See Also:
Home Health Care later in this section.
Skilled Nursing Facilities later in this section.

Cyber Knife Surgery

Covered:
Cyber knife surgery is a covered service if it is used for cancer treatment.

See Also:
Chemotherapy Treatments earlier in this section.
Radiation Therapy Treatments later in this section.

Dental Services

Covered:
Benefits will only be covered under this Plan in the absence of other dental coverage for these procedures or through coordination of medical and dental Benefits, when appropriate. Please see the *Coordination of Your Benefits with Other Plans and Responsible Parties* section of this SPD for information on how the coordination of Benefits works.

Coverage for dental services is limited to the following:

- Dental services rendered by a Dentist or Physician which are required as the result of an Accidental Injury of the teeth, jaws, cheeks, lips, tongue, roof, and floor of the mouth;
- Surgical removal of impacted teeth as an Inpatient or Outpatient procedure in a facility only when you have a medical Condition (such as hemophilia) that required hospitalization;
- Excisions of tumors or cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
- Labial and lingual frenectomies;
- Excisions of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prosthesis;
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands, or ducts;
- Reduction of dislocation of, or excision of, the temporomandibular joints;
- Surgical Treatment of Temporomandibular Joint Dysfunction (TMJ); and
- Jaw dislocation manipulation.

Treatment for dental injuries must be performed within 12 months of the injury in order for the services to be covered under the Medical Plan.

Not Covered:
Benefits will not be provided for dental services or materials, except as described above. This exclusion includes, but is not limited to, diagnostic and preventive dental services, restorative services, endodontic services, periodontal services, surgical removal of impacted teeth (except as noted above), dental cast restorations, dentures, bridges, orthodontic services, injuries associated with the act of

chewing, maxillary and mandibular tooth implants (osseointegration), and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) and Related Disorders.

See Also:
Temporomandibular Joint Dysfunction and Related Disorders later in this section.

Diabetes Training Programs

Covered:
Diabetes training and education programs for the self-management of all types of diabetes mellitus by a Diabetes Educator are covered twice per lifetime for a covered Employee, Spouse, or Child. All covered training or education must be prescribed by a licensed Physician.

This program may be designed to help any type of diabetic and his or her family understand the diabetes disease process and the daily management of diabetes; this includes nutrition education to improve your understanding of your metabolic nutritional Condition and provide you with information to manage your nutritional requirements. Nutrition education related to the diagnosis of diabetes mellitus is appropriate for, but not limited to:

- Glucose intolerance;
- High Blood Pressure;
- Lactose intolerance; and
- Morbid obesity.

Diagnostic Services

Covered:
Benefits will be provided for those services related to covered Surgery or Medical Care.

See Also:
Genetic Testing later in this section.

Digital Breasts Tomosynthesis (3D Mammograms)

Covered:
Benefits will be provided for 3D mammograms based on the following codes:

- 77061 - Digital breast tomosynthesis; unilateral (code is priced as existing code 77055 - Mammography; unilateral)
- 77062 - Digital breast tomosynthesis; bilateral (code is priced as existing code 77056 - Mammography; bilateral)
- 77063 - Screening digital breast tomosynthesis, bilateral (listed separately in addition to code for primary procedure)

Durable Medical Equipment

Covered:
Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and other internal and permanent devices deemed Medically Necessary are covered.

Benefits will also be provided for the rental (but not to exceed the total cost of the equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily manufactured and used to serve a medical purpose. The Claims

Administrator will determine whether to pay the rental amount or the purchase price amount for an item and will also determine the length of any rental term based on the needs of the patient and the cost of the item. Examples of covered items include, but are not limited to, wheelchairs, hospital-type beds, artificial respirators, crutches, casts, oxygen, and equipment needed to administer oxygen.

Benefits will be provided for maintenance and repairs of purchased equipment; however, maintenance needed due to misuse or abuse is not covered. Benefits will also be provided for replacement if needed because of a change in your physical condition and it is likely to cost less to replace the item than to repair the existing item or rent a similar item.

Not Covered:
Benefits will not be provided for items that are not primarily and customarily manufactured and used to serve a medical purpose. Examples of items not covered include, but are not limited to, hot tubs, swimming pools, exercise equipment, braces, splints, appliances, battery implants, humidifiers, air conditioners, elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

The Plan limits coverage to one item of equipment for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

See Also:
Foot Care and Foot Orthotics later in this section.
General Conditions of Coverage, Exclusions, and Limitations section of this SPD.
Leg, Back, Arm and Neck Braces later in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Modifications to Homes, Property, or Automobiles later in this section.
Personal Hygiene, Comfort, and Convenience Items later in this section.
Prosthetic Appliances and Devices later in this section.

Educational or Training Programs

Covered:
Diabetes training programs by Diabetes Educators are covered twice per lifetime through the medical carrier. Contact the medical carrier for assistance. Nutrition and re-education programs are also covered in conjunction with weight loss surgery. Nutritional counseling related to eating disorders is also covered. For details about general nutritional counseling provided through the CHI Wellness Program, call Virgin Pulse at 888-671-9395.

Not Covered:
With the exception of the above-mentioned programs, Benefits will not be provided for treatment or services that are provided for educational or training purposes.

See Also:
Diabetes Training Programs earlier in this section.

Eligible Charges for Multiple Surgical Procedures

Covered:
If you or one of your Dependents undergo two or more operations during any one time, covered charges for the services of the Physician for each procedure that is clearly identifiable as a separate procedure will be based on:

- 100 percent of Eligible Charges for the first or primary operation; and
- 50 percent of Eligible Charges for the second or subsequent operation.

Emergency Services

Covered:
Benefits for Emergency Accident Care or Emergency Medical Care will be provided at 100 percent of the Eligible Charge after the applicable Copayment if it meets the definition of an Emergency or Medically Urgent Situation as found in the *Glossary of Terms* section of this SPD. This Benefit will be the same when services are rendered from a Catholic Health Initiatives Facility, an In-Network Provider, or an Out-of-Network Provider. The Copayment will be waived if you are admitted as an Inpatient.

Under the Integrated HDHP/HSA option, you must meet the Deductible before the plan begins to pay benefits for Emergency Accident Care and Emergency Medical Care. However, if admitted to the Hospital, the Copayment will be waived, and Inpatient pre-notification requirements, as well as Inpatient Benefits will apply.

Not Covered:
You may be billed for the difference between the Medicare allowed and the provider billed charges.

See also:
Ambulance Transportation earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Non-Emergency Use of the Emergency Room later in this section.

Eye Examinations and Eye-Related Diagnostic Services

Covered:
Benefits will be provided for eye examinations for the purpose of diagnosing a medical Condition, such as eye exams or refractions to diagnose or treat diabetes. In addition, routine vision exams will be covered, but only for newborns and Children when billed as part of a well-child visit. One eye exam and refraction will be allowed following cataract surgery.

Not Covered:
Benefits will not be provided for examinations to determine the refractive state of the eyes, auditory problems, surveys, case findings, research studies, screenings, or similar procedures and studies, or tests which are Investigational in nature.

See Also:
Eyeglasses, Contact Lenses, or Cataract Lenses later in this section.
Kerato-Refractive Eye Surgery later in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.

Optometry Services later in this section.
Retinal Eye Exam later in this section.
Vision Services later in this section.

Eyeglasses, Contact Lenses, or Cataract Lenses

Covered:
The first pair of either eyeglasses or contact lenses needed after cataract Surgery, cornea transplantation, or cornea grafting is covered.

Not Covered:
Benefits will not be provided for eyeglasses, contact lenses, or cataract lenses with the exception of the first pair for the Conditions listed above.

See Also:
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Kerato-Refractive Eye Surgery later in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Optometry Services later in this section.
Vision Services later in this section.

Failure to Keep a Scheduled Appointment

Not Covered:
Benefits will not be provided for charges for failure to keep a scheduled appointment.

Family Members Who Provide Services

Not Covered:
Benefits will not be provided for medical services and supplies provided by a member of your family or household. "Member of your family" means yourself; your Spouse; Legally Domiciled Adult; natural or adoptive parent; Child; sibling; step-parent or step-Child; step or half-brother; step or half-sister; mother-in-law or father-in-law; son-in-law or daughter-in-law; brother-in-law or sister-in-law; grandparent or grandchild; or Spouse of a grandparent or grandchild.

Fertility Treatment

Covered:
Expenses for Covered Services related to the diagnosis and/or medical treatment of Infertility when rendered in conjunction with conception through normal intercourse are covered. Fertilization must occur within the woman's body.

Your Benefits for the medical treatment of Infertility and all related services and supplies are subject to a Lifetime Maximum of $15,000 per covered individual. Covered procedures include, but are not limited to, Gamete Intrafallopian Transfer (GIFT), and Lower Tubal Ovum Transfer. Fertility drugs are limited to a separate Lifetime Maximum of $5,000 per covered individual.

Not Covered:
Benefits will not be provided for services and supplies rendered or provided for the treatment of fertility in which fertilization takes place outside of the woman's body. Specifically excluded, without limiting this exclusion to these procedures, are all services and supplies related to in-vitro fertilization,

artificial insemination, embryo transfers, donor charges, Zygote Intrafallopian Transfer (ZIFT), and cryopreservation.

Foot Care and Foot Orthotics

Covered:
Benefits will be provided twice during the Benefit Year for Medically Necessary custom-made foot orthotics provided by an Orthotic Provider. Benefits are also provided for foot care that is determined to be Medically Necessary.

See Also:
Durable Medical Equipment earlier in this section.
Leg, Back, Arm, and Leg Braces later in this section.
Prosthetic Appliances and Devices later in this section.

Genetic Testing

Covered:
Genetic molecular testing (specific gene identification) and related counseling are covered when **both** of the following requirements are met:

- You are an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.); and
- The outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational.

See Also:
Diagnostic Services earlier in this section.

Hearing Examinations and Hearing Aids

Covered:
Benefits will be provided for hearing examinations for the purpose of diagnosing a medical Condition. In addition, routine hearing examinations will be covered, but only for newborns and Children when billed as routine and included as a part of a well-child visit.

Not Covered:
Benefits will not be provided for pure tone audiometry tests, when part of a routine diagnosis. Benefits are not provided for hearing aids or the examinations for the prescription or fitting of hearing aids.

Home Health Care

Covered:
Comprehensive medical Covered Services will include charges by a Home Health Care Program or agency for:

- Private Duty Nursing Services;
- Part-time or intermittent home care by a home health aide;
- Physical, Occupational, Speech, or respiratory therapy;
- Intermittent services of a registered dietician or social worker;
- Part-time or intermittent home care by any other individual of the home health care team;
- Drugs and medicines which require a Physician's prescription, as well as other supplies prescribed by the attending Physician; or

- Laboratory services;

The above charges are covered only to the extent that such services and supplies are provided under the terms of a Home Health Care Plan. These Covered Services are subject to all provisions of the Medical Plan that would apply to any other medical treatment or service.

The home health care services must be rendered in accordance with a prescribed Home Health Care Plan. The Home Health Care Plan must be:

- Established prior to the initiation of the home health care services;
- Prescribed by the attending Physician at least once every 30 days; and
- Required as a result of an Illness or Accidental Injury.

Pre-notification is required prior to the initiation of home health care to assist you or your Dependent in determining whether or not the proposed treatment or service is appropriate for reimbursement under this Plan.

The general comprehensive medical limitations and maximums listed in this SPD will apply to home health care.

Not Covered:
Comprehensive medical Covered Services for home health care will not include:

- Services or supplies not included in the Home Health Care Plan;
- The services of any person in your or your Dependent's immediate family, or any person who normally lives in your or your Dependent's home;
- Custodial Care (services or supplies provided to assist a person in daily living, e.g., meals and personal grooming); or
- Transportations services.

See Also:
Ambulance Transportation earlier in this section.
Family Members Who Provide Services earlier in this section.
Personal Hygiene, Comfort, and Convenience Items later in this section.

Hospice Care Program Services

Covered:
Benefits will be provided for Hospice Care Program Services as described below when these services are rendered to you by a Hospice Care Program Provider. However, for Benefits to be available, you must have a terminal Illness with a life expectancy of 12 months or less, as certified by your attending Physician; and you will no longer benefit from standard Medical Care or have chosen to receive Hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from the Hospice Care Program Providers if Hospice care is being provided in the home.

The following are eligible Hospice Care Program Providers:

- Hospice facility;
- Hospital;
- Convalescent facility; and
- Home Hospice.

The following services are covered under the Hospice Care Program:

- Home Health Care;
- Medical supplies and dressings;
- Prescription medication;
- Skilled and non-Skilled Nursing Services;
- Occupational Therapy;
- Pain management services;
- Physical Therapy;
- Physician visits;
- Medical social services under the direction of a Physician;
- Psychological and dietary counseling; and
- Bereavement counseling.

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as Inpatient Hospital Covered Services.

See Also:
Family Members Who Provide Services earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Personal Hygiene, Comfort, and Convenience Items later in this section.

Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary

Not Covered:
Benefits will not be provided for services which are not determined to be Medically Necessary.

Hospitalization is not Medically Necessary when, in reasonable medical judgment, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's Condition.

Examples of hospitalization and other health care services that are not Medically Necessary include but are not limited to:

- Hospital Admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department;
- Hospital Admissions primarily for diagnostic studies (x-ray, laboratory and pathological services, and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office;
- A continued Inpatient Hospital care, when the patient's medical symptoms and Condition no longer require continued stay in a Hospital;
- Hospitalization or Admission to a Skilled Nursing Facility, nursing home, or other facility for primary purposes of providing Custodial Care Services, convalescent care, rest cures, or domiciliary care to the patient;
- Hospitalization or Admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable; and
- The use of skilled or private duty nurses to assist in daily living activities or routine supportive care or to provide services for the convenience of the patient and/or family members.

The examples above do not comprise an exhaustive list of hospitalizations or other services and supplies that are not Medically Necessary.

The Claims Administrator will make the decision whether hospitalizations or other health care services or supplies are Medically Necessary and whether they are eligible for payment under the terms of the Medical Plan.

In some instances, this decision may be made by the Claims Administrator after you have been hospitalized or have received other health care services and after a Claim for payment has been submitted. The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services or supplies as Medically Necessary, does not make the hospitalization, services, or supplies Medically Necessary under the Medical Plan and does not mean that hospitalization, services, or supplies will be covered under the Plan.

See Also:
Assistant Surgeons earlier in this section.
Inpatient Hospital Care later in this section.
Outpatient Hospital Care later in this section.
Physicians later in this section.
Skilled Nursing Facilities later in this section.
Surgery later in this section.

Human Organ Transplants

Covered:
The following human-to-human organ transplant procedures will be considered Covered Services, subject to all limitations and maximums described in this SPD, for a patient that is covered under this Plan. Benefits will only be covered for Medically Necessary procedures that are not Investigational for your specific Condition. These include:

- Cornea;
- Kidney;
- Bone Marrow;
- Peripheral stem cell infusion;
- Heart Valve;
- Muscular-skeletal;
- Parathyroid;
- Heart;
- Lung;
- Heart/lung;
- Liver;
- Pancreas;
- Small bowel;
- Pancreas/Kidney; and
- Tissue transplants.

Benefits are available to both the recipient and donor of a transplant as follows:

- If both the donor and the recipient have coverage, each will have their Benefits paid by their own Plan.

- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the Benefits described in this section of the SPD will be provided for both you and the donor. In this case, payments made for the donor will be charged against your Benefits.
- If you are the donor for the transplant and no other coverage is available to you from any other source, the Benefits described in this SPD will be provided for you. However, no Benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery;
- Evaluation, preparation, and delivery of the donor organ;
- Removal of the organ from the donor; and
- Transportation of the donor organ to the location of the transplant Surgery; however, Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, Benefits for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants will be provided as follows:

- The CHI Medical Plan Customer Service Team will furnish you with the names of Hospitals which are approved Human Organ Transplant Program Hospitals or you may use a CHI Facility.
- Covered Services will include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose Chemotherapy, which has been determined to be Medically Necessary.
    - The Benefit for cryopreservation and storage of bone marrow or peripheral stem cells will not exceed $10,000 per approved transplant in a non-CHI Facility Hospital or a hospital that is not a Human Organ Transplant Program Hospital.
- If you are the recipient of the transplant, Benefits will be provided for reasonable, demonstrated transportation, lodging, and meals for you and a companion. If the recipient of the transplant is a Dependent Child under the age of 19, Benefits for transportation, lodging, and meals will be provided for two companions. For Benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
    - Benefits for reasonable, demonstrated transportation, lodging, and meals are limited to a maximum of $10,000 per transplant. This includes all transplants.

<u>Not Covered:</u>

Benefits will not be provided for:

- Transportation, lodging and meal expense if services are not provided by a Human Organ Transplant Program Hospital or a CHI Facility Hospital;
- Transplants that are not Medically Necessary or are Investigational in nature;
- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery;
- Travel time and related expenses required by a Provider;
- Drugs which are Investigational or do not have approval of the Food and Drug Administration;
- Cryopreservation and storage, except as described above;
- Animal-to-human organ transplants;
- Implantation within the human body of artificial or mechanical devices designed to replace human organ(s); and
- Services provided to any individual who is not the recipient or actual donor unless specified above.

See Also:
Notification Requirement and Care Coordination section of this SPD.
Surgery later in this section.
Travel and Lodging later in this section.

Inpatient Hospital Care

Covered:
The following are Covered Services when you receive them as an Inpatient in a Hospital:

- Bed, board and general nursing care when you are in
    - A semi-private room;
    - A private room, when Medically Necessary;
    - An Intensive Care Unit; or
    - A Coronary Care Unit.
- Ancillary services (such as operating rooms, drugs, surgical dressings, x-rays, and lab work)

If you are in a private room, Benefits will be limited by the Hospital's rate for its most common type of room with two or more beds, unless the use of a private room is determined to be Medically Necessary.

Not Covered:
Benefits will not be provided for hospitalizations which are not Medically Necessary. Additionally, personal hygiene, comfort and convenience items such as telephones, televisions, and guest trays are not covered.

See Also:
Ambulance Transportation earlier in this section.
Anesthesia Services earlier in this section.
Assistant Surgeons earlier in this section.
Blood and Blood Administration earlier in this section.
Cardiac Rehabilitation Services earlier in this section.
Chemotherapy Treatments earlier in this section.
Completion of Claim Forms, Reports, or Medical Records earlier in this section.
Custodial Care Services earlier in this section.
Diagnostic Services earlier in this section.
Emergency Services earlier in this section.
Family Members Who Provide Services earlier in this section.
Genetic Testing earlier in this section.
Home Health Care earlier in this section.
Hospice Care Program Services earlier in this section.
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Occupational Therapy later in this section.
"-ologists" at In-Network and CHI Facilities later in this section.
Outpatient Hospital Care later in this section.
Oxygen and Its Administration later in this section.
Personal Hygiene, Comfort, and Convenience Items later in this section.
Physical Therapy later in this section.
Physicians later in this section.

Pre-Admission Testing later in this section.
Radiation Therapy Treatments later in this section.
Shock Therapy Treatments later in this section.
Skilled Nursing Facilities later in this section.
Speech Therapy later in this section.
Substance Abuse Rehabilitation Treatment later in this section.
Surgery later in this section.
X-Ray and Laboratory Services later in this section.

Kerato-Refractive Eye Surgery

Not Covered:
Benefits will not be provided for treatment or services or materials for Kerato-Refractive Eye Surgery (Surgery to improve near-sightedness and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis Surgery).

See Also:
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Eyeglasses, Contact Lenses and Cataract Lenses earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Optometry Services later in this section.
Vision Services later in this section.

Leg, Back, Arm and Neck Braces

Covered:
Benefits will be provided for leg back, arm, and neck braces.

See Also:
Durable Medical Equipment earlier in this section.
Foot Care and Foot Orthotics earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Modifications to Homes, Property, or Automobiles later in this section.
Prosthetic Appliances and Devices later in this section.

Marriage Counseling

Covered:
Benefits will be provided for Marriage Counseling when provided by a pastoral counselor, licensed mental health counselor, Licensed Marriage and Family Therapist or a licensed Psychologist.

When you receive Covered Services in an In-Network Provider's office for marriage counseling, these services will be paid at the same level of Benefits as an office visit.

Massage Therapy

Covered:
Benefits will be provided for Massage Therapy if it is determined to be Medically Necessary and prescribed by a Physician for chronic pain. This can be performed by a Physician, Physical Therapist, Chiropractor or a licensed Massage Therapist. If performed by a licensed Massage Therapist, this

therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician.

The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Benefits shall not be provided for maintenance Massage Therapy. Benefits for Massage, Occupational, Physical, and Speech Therapies will have a combined Benefit limit of 30 visits per Benefit Year per covered individual. This is a combined limit between visits to In-Network and Out-of-Network Providers. CHI Facilities are not subject to this 30-visit limitation.

Not Covered:
Benefits will not be provided for Maintenance Massage Therapy.

See Also:
Occupational Therapy later in this section.
Physical Therapy later in this section.
Speech Therapy later in this section.

Mastectomy and Related Services

Covered:
Benefits for Covered Services related to mastectomies are the same as for any other Condition. Covered Services include, but are not limited to:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy including, but not limited to lymphedemas.

See Also:
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this SPD.
Prosthetic Appliances and Devices later in this SPD.

Maternity Services

Covered:
Your Benefits for Maternity Services are the same as your Benefits for any other Condition. Benefits will be provided for Covered Services rendered by a Physician, Physician's Assistant, Nurse Practitioner, or Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and complications of pregnancy. The following Preventive Care services related to Maternity Services will be covered at 100 percent, as required by the Patient Protection and Affordable Care Act:

- Purchase of a standard (non-hospital grade) electric breast pump within the first 60 days following delivery;
- Purchase of a manual breast pump within the first 12 months (365 days) following delivery;
- Rental of a heavy duty electrical (hospital grade) breast pump for the period of time that a newborn is detained in the hospital; and
- For women using a breast pump from a prior pregnancy, a new set of breast pump supplies will be covered with each subsequent pregnancy within the first 12 months following delivery.

- Prenatal care received by a pregnant female is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check). Prenatal physician office visits will only be covered at 100 percent if they are billed separately from other services that are not covered at 100 percent as Preventive Care.

If the newborn Child needs treatment for an Illness or Accidental Injury, the newborn must be enrolled in the Medical Plan as a Dependent. You must enroll your newborn within 60 days after birth for the infant to be covered under the Plan. If enrolled within 60 days of birth, the newborn's coverage will be effective from the date of the birth.

Not Covered:
Benefits will not be provided for nursery charges once the mother is discharged from the Hospital or any other charges not explicitly listed above as a Covered Service if your newborn does not meet the definition of a Dependent Child or if the newborn is not enrolled in the Plan within 60 days of birth.

See Also:
Adding or Dropping Coverage section of this SPD.
Glossary of Terms section of this SPD.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Personal Hygiene, Comfort and Convenience Items later in this section.
Prenatal Care Program later in this section.

Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes

Covered:
Benefits are provided for medical and surgical dressings, supplies, casts, splints, crutches, and artificial eyes.

See Also:
Durable Medical Equipment earlier in this section.
Foot Care and Foot Orthotics earlier in this section.
Leg, Back, Arm and Neck Braces earlier in this section.
Modifications to Homes, Property, or Automobiles later in this section.
Prosthetic Appliances and Devices later in this section.

Mental Health Services

Covered:
Benefits for all of the Covered Services previously described in this SPD are available for the diagnosis and/or treatment of an Illness Affecting Mental Health. Medical Care for the treatment of an Illness Affecting Mental Health is covered when rendered by a:

- Physician;
- Psychologist, Clinical Social Worker, or Clinical Professional Counselor working within the scope of his or her license;
- Spiritual counselor who holds a pastoral counseling degree; or
- Licensed Marriage Family Therapist.

Additional counselors may also be covered when supervised by a Physician. Please contact the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card for more information.

See Also:
Completion of Claim Forms, Reports, or Medical Records earlier in this section.
Custodial Care Services earlier in this section.
Failure to Keep a Scheduled Appointment earlier in this section.
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary earlier in this section.
Marriage Counseling earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Residential Treatment Facilities later in this section.
Substance Abuse Rehabilitation Treatment later in this section.

Modifications to Homes, Property, or Automobiles

Not Covered:
Benefits shall not be provided for modifications made to a home, property, or automobile, such as ramps, elevators, spas, and car hand controls.

See Also:
Durable Medical Equipment earlier in this section.
Foot Care and Foot Orthotics earlier in this section.
Leg, Back, Arm and Neck Braces earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
Prosthetic Appliances and Devices later in this section.

Nephropathy Screening

Covered:
Benefits for screening to detect kidney disease resulting from diabetes.

Not Covered:
Benefits shall not be provided for non-diabetic patients.

See Also:
Diabetes Training Programs earlier in this section.
Diabetes Care Program section of this SPD.
Retinal Eye Exam later in this section.

Non-Emergency Use of the Emergency Room

Covered:
Benefits for non-Emergency use of the Emergency room will be provided based on the *Highlights of the Medical Plan Options*.

See Also:
Emergency Services earlier in this section.

Non-Prescription Drug Medications

Covered:
Benefits will be provided for Vitamin B-12 injections when determined to be Medically Necessary. Additionally, enteral feedings will be covered as part of a Hospice Care Program Service or if the sole source of feeding, such as for someone who has oral or throat cancer.

Not Covered:
Benefits shall not be provided for drugs or medicines that do not require a Physician's prescription, vitamins (except Vitamin B-12 injections when determined to be Medically Necessary), minerals, nutritional supplements (except enteral feedings in relation to Hospice), or special diets (whether they require a Physician's prescription or not).

See Also:
Prescription Drugs later in this section.

Occupational Therapy

Covered:
Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment begins and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals.

Benefits for Massage, Occupational, Physical, and Speech Therapies will have a combined Benefit limit of 30 visits per Benefit Year per covered individual. This is a combined limit between visits to In-Network and Out-of-Network Providers. CHI Facilities are not subject to this 30 visit limitation.

Not Covered:
Benefits shall not be provided for Maintenance Occupational Therapy.

See Also:
Massage Therapy earlier in this section.
Physical Therapy later in this section.
Speech Therapy later in this section.

Office Visits

Covered:
Benefits will be provided for office visits as set forth in this section. The office visit benefit includes the consultation with a physician regarding the diagnosis and treatment of a medical condition, as well as any services bundled with the office visit claim (meaning services performed by the provider, at the provider's office and during the office visit). Office visits for preventive care (such as a routine physical) are covered as described in the *Preventive or Wellness Care* section.

Not Covered:
Any services that are provided by a different provider or at a different location (such as lab services, x-rays, office procedures or other ancillary charges) are not covered under the office visit benefit. These services are still covered under the Plan but will be subject to applicable Coinsurance and Deductible.

See Also:
Physicians later in this section.
Preventive or Wellness Care later in this section.
Routine Physical Exams later in this section.

Outpatient Hospital Care

Covered:
The following are examples of Covered Services when you receive them from a Hospital as an Outpatient:

- Surgery and any related Diagnostic Services received on the same day as the Surgery;
- Radiation therapy treatments;
- Chemotherapy;
- Shock therapy treatments;
- Renal Dialysis Treatments – if received in a Hospital, a Dialysis Facility, or in your home under the supervision of a Hospital or Dialysis Facility Provider;
- Diagnostic Services – when you are an Outpatient and these services are related to Surgery or Medical care;
- Emergency Accident Care;
- Emergency Medical Care; and
- Outpatient Surgery.

Outpatient Hospital care does not require pre-notification.

See Also:
Ambulance Transportation earlier in this section.
Anesthesia Services earlier in this section.
Assistant Surgeons earlier in this section.
Blood and Blood Administration earlier in this section.
Cardiac Rehabilitation Services earlier in this section.
Chemotherapy Treatments earlier in this section.
Completion of Claim Forms, Reports, or Medical Records earlier in this section.
Diagnostic Services earlier in this section.
Emergency Services earlier in this section.
Family Members Who Provide Services earlier in this section.
Genetic Testing earlier in this section.
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary earlier in this section.
Inpatient Hospital Care earlier in this section.
Occupational Therapy earlier in this section.
"-ologists" at Network and CHI Facilities later in this section.
Oxygen and Its Administration later in this section.
Personal Hygiene, Comfort, and Convenience Items later in this section.
Physical Therapy later in this section.
Physicians later in this section.
Pre-Admission Testing later in this section.
Preventive or Wellness Care later in this section.
Radiation Therapy Treatments later in this section.
Shock Therapy Treatments later in this section.

Speech Therapy later in this section.
Substance Abuse Rehabilitation Treatment later in this section.
Surgery later in this section.
X-Ray and Laboratory Services later in this section.

"-ologists" at In-Network and CHI Facilities

Covered:
When you seek Inpatient or Outpatient Hospital treatment at a CHI Facility or an In-Network Provider, Benefits for pathologists, radiologists, anesthesiologists, and emergency room specialists will be provided at the In-Network percentage level after you have met your In-Network Deductible, even if it is for an Out-of-Network Provider. However, costs for services received from an Out-of-Network provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges. You may be billed for the difference between the Medicare allowable rate and the provider's billed charges.

Not Covered:
This does not apply to assistant surgeons.

See Also:
Anesthesia Services earlier in this section.

Optometry Services

Not Covered:
Benefits will not be provided for Optometry services that are covered under the CHI Vision Plan.

See Also:
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Eyeglasses, Contact Lenses, or Cataract Lenses earlier in this section.
Kerato-Refractive Eye Surgery earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
Retinal Eye Exam later in this section.
Vision Services later in this section.

Oxygen and Its Administration

Covered:
Benefits will be provided for oxygen and its administration.

Personal Hygiene, Comfort, and Convenience Items

Not Covered:
Benefits shall not be provided for personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones.

See Also:
Inpatient Hospital Care earlier in this section.

Outpatient Hospital Care earlier in this section.
Skilled Nursing Facilities later in this section.

Physical Therapy

Covered:
Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals.

Benefits for Massage, Occupational, Physical, and Speech Therapies will have a combined benefit limit of 30 visits per Benefit Year per covered individual. This is a combined limit between visits to In-Network and Out-of-Network Providers. CHI Facilities are not subject to this 30 visit limitation.

Not Covered:
Benefits shall not be provided for Maintenance Physical Therapy.

See Also:
Massage Therapy earlier in this section.
Occupational Therapy earlier in this section.
Speech Therapy later in this section.

Physicians

Covered:
Benefits will be provided for the following Covered Services:

- Office visits;
- Hospital visits and visits to other covered facilities;
- Physician's visits in your home;
- Surgery, whether Inpatient or Outpatient;
- Diagnostic Services;
- Medical care;
- Care for Accidental Injuries;
- Emergency Medical Care; and
- Certain consultations.

However, the above is not an exhaustive list of the types of Covered Services and Supplies that might be provided by your Physician

Not Covered:
Benefits shall not be covered for services provided by:

- Athletic trainers;
- Dental assistants or dental hygienists;
- Hypnotists;
- Homeopathic medical Providers;
- Priests and other religious affiliates;
- Naturopaths;

- Opticians;
- Orthodontists;
- Residents, interns, or other Employees of Hospitals or Skilled Nursing Facilities who bill separately for their services and are not listed as a Provider or Professional Provider in the *Glossary of Terms* section of this SPD; and
- Other non-traditional medical Providers.

See Also:
Completion of Claim Forms, Reports, or Medical Records earlier in this section.
Failure to Keep a Scheduled Appointment earlier in this section.
"-ologists" at In-Network and CHI Facilities earlier in this section.
Provider or Professional Provider in the *Glossary of Terms* section of this SPD.

Pre-Admission Testing

Covered:
Benefits will be provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided the Benefits would have been available to you had you received these tests as an Inpatient in a Hospital.

These tests are considered part of your Inpatient Hospital Surgical stay.

See Also:
Inpatient Hospital Care earlier in this section.
Surgery later in this section.

Prenatal Care Program

Covered:
The prenatal care program is a voluntary program designed to help mothers-to-be understand and manage every stage of pregnancy from the first trimester through newborn care. To enroll, call Virgin Pulse at 1-866-852-6898. A representative will ask you several questions about your health and enroll you in the program. Once you have completed the program, you will receive a $150.00 incentive as a contribution to a health account. Allow up to 30 days after completion for payment.

See Also:
Maternity Services earlier in this section.

Prescription Drugs

Covered:
Benefits will be provided for certain Prescription Drugs or medications through the Prescription Drug Program. Covered drugs are limited to those taken orally, absorbed through the skin, and certain injected Prescription Drugs. Benefits will be provided only if such drugs are Medically Necessary. Prescription Drugs may be dispensed through a retail Pharmacy or the mail-order drug program. The following are considered covered drugs under the Prescription Drug Program:

- Legend Drugs
- State restricted drugs;
- Insulin;
- Insulin needles and syringes;
- Over-the-counter diabetic supplies;

- Legend topical fluoride products;
- Retin-A (cream, gel and liquid dosage forms) and Avita for patients up to and including age 35;
- Self-administered injectables;
- Fertility medications (Limited to a lifetime maximum of $5,000 per individual);
- Contraceptive jellies, creams, foams, devices, implants, or injections (refer to *Contraceptives and Contraceptive Devices* section for coverage details); and
- Oral contraceptives (refer to *Contraceptives and Contraceptive Devices* section for coverage details).

Not Covered:
The following shall not be considered covered drugs under the Prescription Drug Program for the following:

- Non-federal legend drugs;
- Contraceptive jellies, creams, foams, devices, implants, or injections (refer to *Contraceptives and Contraceptive Devices* section for coverage details);
- Mifeprex (morning after pill);
- Oral contraceptives (refer to *Contraceptives and Contraceptive Devices* section for coverage details);
- Injectable medications (except self-administered medications);
- Smoking deterrents;
- Retin-A (dosage form gel or liquid) for patients age 36 and older;
- Drugs used to treat impotency;
- Therapeutic devices or appliances (not covered under the Prescription Drug Benefit but may be covered under the medical Benefits);
- Ostomy supplies (not covered under the Prescription Drug Benefit but may be covered under the medical Benefits);
- Biologicals, insulin pumps, blood, and blood plasma (not covered under the Prescription Drug Benefit but may be covered under the medical Benefits);
- Drugs whose sole purpose is to promote or stimulate hair growth;
- Drugs prescribed for cosmetic purposes;
- Drugs labeled, "Caution-limited by Federal law to Investigational use" or experimental drugs, even if a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the Employee or Dependent;
- Any prescription filled in excess of the number of refills specified by the Physician; or
- Any refill dispensed after one year from the Physician's original prescription.

See Also:
Appealing a Denied Medical or Pharmacy Claim section of this SPD.
Contraceptives and Contraceptive Devices earlier in this section.
Durable medical Equipment earlier in this section
Medical and Pharmacy Claims Procedures section of this SPD.
Network Details – Choosing a Provider section of this SPD.
Non-Prescription Drug Medications earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Smoking/Tobacco Cessation Prescription Drugs later in this section.

Preventive or Wellness Care

Covered:
Benefits will be provided for Covered Services for Preventive or Wellness Care rendered to you, even though you are not ill.

Covered services include but are not limited to the following:

- Immunizations;
- Routine history and physical examinations;
- Routine history and gynecological exams;
- Pap smears;
- Routine history and pediatric exams (well-child visits);
- Routine Colonoscopies;
- Routine Preventive Care tests and laboratory screenings;
- Routine mammograms;
- Routine prostate tests;
- Routine vision and hearing exams, but only for newborns and Children when billed as routine or included as part of a well Child visit;
- Counseling for tobacco cessation, weight loss and/or misuse of alcohol or drugs.

Other services may be covered based on the current recommendations of the United States Preventive Services Task Force and the Health Resources and Services Administration.

See Also:
Office Visits earlier in this section.
Routine Physical Exams later in this section.
Smoking/Tobacco Cessation Prescription Drugs later in this section.

Prosthetic Appliances and Devices

Covered:
Benefits will be provided for prosthetic devices, special appliances, and surgical implants when they are required to replace all or part of:

- An organ or tissue of the human body, or
- The function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repairs, and replacements of covered prosthetic devices, special appliances, and surgical implants when required because of wear or change in a patient's Condition.

Not Covered:
Benefits shall not be provided for dental appliances.

Additionally, Benefits will not be provided for prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of an Illness or Accidental Injury.

See Also:
Durable Medical Equipment earlier in this section.
Foot Care and Foot Orthotics earlier in this section.
Leg, Back, Arm and Neck Braces earlier in this section.

Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
Modifications to Homes, Property, or Automobiles earlier in this section.
Temporomandibular Joint Dysfunction and Related Disorders later in this section.

Radiation Therapy Treatments

Covered:
The use of Radiation Therapy Treatments to treat or control a serious Illness is covered.

Not Covered:
Benefits shall not be provided for any service that is considered Investigational as it relates to a particular Illness.

See Also:
Chemotherapy Treatments earlier in this section.
Cyber Knife Surgery earlier in this section.

Residential Treatment Facilities

Covered:
Benefits for Diagnostic Tests, X-Ray and Laboratory charges related to the residential treatment will be covered. Benefits will also be provided for room and board charges with proper prior authorization.

Not Covered:
Benefits shall not be provided for halfway houses or boarding houses.

See Also:
Mental Health Services earlier in this section.
Substance Abuse Rehabilitation Treatment later in this section.

Retinal Eye Exam

Covered:
Benefits for retinal eye exams for diabetic patients.

Not Covered:
Benefits shall not be provided for non-diabetic patients.

See Also:
Diabetes Training Programs earlier in this section.
Diabetes Care Program section of this SPD.
Nephropathy Screening earlier in this section

Routine Physical Exams

Covered:
Routine physical exams are covered under preventive and Wellness Care based on the current recommendations of the United States Preventive Services Task Force and the Health Resources and Services Administration (ACA guidelines.)

See Also:
Preventive and Wellness Care earlier in this section.

Self Help Programs

Not Covered:
Benefits shall not be provided for self-help programs and self-cure products, drugs or herbal remedies.

Shock Therapy Treatments

Covered:
Benefits will be provided for shock therapy treatments.

Skilled Nursing Facilities

Covered:
Benefits will be provided for the following Covered Services when you receive them in a skilled Nursing Facility:

- Bed, board, and general nursing care; and
- Ancillary services, such as, but not limited to, drugs and surgical dressings or supplies.

Not Covered:
Benefits shall not be provided for an uncertified Skilled Nursing Facility.

See Also:
Ambulance Transportation earlier in this section.
Cardiac Rehabilitation Services earlier in this section.
Custodial Care Services earlier in this section.
Family Members Who Provide Services earlier in this section.
Hearing Examinations and Hearing Aids earlier in this section.
Home Health Care earlier in this section.
Hospice Care Program Services earlier in this section.
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Oxygen and its Administration earlier in this section.
Personal Hygiene, Comfort, and Convenience Items earlier in this section.

Sleep Apnea Treatment

Covered:
Benefits will be provided for obstructive sleep apnea diagnosis and treatments.

Not Covered:
Benefits shall not be provided for snoring without a diagnosis of obstructive sleep apnea.

Smoking/Tobacco Cessation Prescription Drugs

Covered:
Smoking/tobacco cessation prescription drugs are covered 100 percent as a preventive benefit if prescribed by a physician through the Medical Plan. You can also participate in the smoking cessation program through the CHI Wellness Program.

Not Covered:
Benefits shall not be provided for treatment or services of smoking/tobacco cessation, except as specifically provided above.

See Also:
Preventive or Wellness Care earlier in this section

Speech Therapy

Covered:
Benefits will be provided for Speech Therapy, including Speech Therapy required due to developmental delay, when these services are rendered by a licensed Speech Therapist or a Speech Therapist certified by the American Speech and Hearing Association under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Inpatient Speech Therapy Benefits will be provided only if Speech Therapy is not the only reason for Admission.

Benefits for Massage, Occupational, Physical, and Speech Therapies will have a combined benefit limit of 30 visits per Benefit Year per covered individual. This is a combined limit between visits to In-Network and Out-of-Network Providers. CHI Facilities are not subject to this 30 visit limitation.

Not Covered:
Benefits will not be provided for Maintenance Speech Therapy.

See Also:
Massage Therapy earlier in this section.
Occupational Therapy earlier in this section.
Physical Therapy earlier in this section.

Sterilization Procedures

Covered:
Benefits will be provided for the reversal of sterilization procedures, including reverse tubal ligations and reverse vasectomies.

Not Covered:
Benefits shall not be provided for elective sterilization procedures, including tubal ligations and vasectomies.

See Also:
Abortions earlier in this section.
Contraceptives and Contraceptive Devices earlier in this section.
Surgery later in this section.

Substance Abuse Rehabilitation Treatment

Covered:
Benefits shall be provided for Covered Services for Substance Abuse Rehabilitation Treatment and Substance Abuse Treatment Facilities.

Not Covered:
Benefits shall not be provided for halfway houses or boarding houses.

See Also:
Residential Treatment Facilities earlier in this section.

Surgery

Covered:
Benefits will be provided for Surgery performed by a Physician, Dentist, or Podiatrist. However, for services performed by a Dentist or Podiatrist, Benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under the Medical Plan had they been performed by a Physician.

Not Covered:
Benefits shall not be provided for Surgery that is not Medically Necessary, cosmetic Surgery or for weight loss Surgery that does not meet the requirements of this Plan.
See Also:
Abortions earlier in this section.
Assistant Surgeons earlier in this section.
Blood and Blood Administration earlier in this section.
Cosmetic Surgery earlier in this section.
Eligible Charges for Multiple Surgical Procedures earlier in this section.
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Human Organ Transplants earlier in this section.
Kerato-Refractive Eye Surgery earlier in this section.
Maternity Services earlier in this section.
Mastectomy and Related Services earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
"-ologists" at In-Network and CHI Facilities earlier in this section.
Pre-Admission Testing earlier in this section.
Sterilization Procedures earlier in this section.
Weight Loss Surgery later in this section.

Temporomandibular Joint Dysfunction and Related Disorders

Covered:
Benefits shall be provided for TMJ Surgery.

Not Covered:
Diagnosis and non-surgical treatment of TMJ shall not be covered under this Plan; however, it is covered under the dental plan.

Transgender Reassignment Surgery

Not Covered:
Benefits shall not be provided for gender reassignment surgery including, but not limited to, any treatments, drugs, medicines, therapy, counseling services or supplies related to such surgeries.

Travel or Lodging Costs

Covered:
Travel and lodging costs when related to a human organ transplant, and only to the extent described as a Covered Service in the *Human Organ Transplant* section above.

Not Covered:
Benefits shall not be provided for travel and lodging costs except as described as a Covered Service under this Plan within this SPD.

See Also:
Ambulance Transportation earlier in this section.
Human Organ Transplants earlier in this section.

Vision Services

Covered:
Benefits will be provided for vision examinations for newborns and Children as part of a routine medical exam. Benefits will also be provided for vision examinations when related to an Accidental Injury or an Illness such as diabetes.

Not Covered:
Benefits shall not be provided for:

- Surgery to correct a refractive error (i.e., when the shape of your eye does not bend light correctly, resulting in blurred images);
- Eye glasses or contact lenses, unless otherwise stated within this SPD, including charges related to their fitting;
- Eye exercises;
- Prescribing of corrective lenses;
- Eye examinations for the fitting of eyewear; and
- Routine vision exams, except for vision exams for newborns and Children as part of a medical exam, or when related to an Accidental Injury or an Illness such as diabetes.

See Also:
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Eyeglasses, Contact Lenses, or Cataract Lenses earlier in this section.
Kerato-Refractive Eye Surgery earlier in this section.
Optometry Services earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
Retinal Eye Exam earlier in this section.

Web Cam Consultations

Covered:
Web cam consultations will be covered the same as an office visit when provided by a covered Provider.

See Also:
Consultations earlier in this section.

Weight Loss Prescription Drugs

Not Covered:
Benefits will not be provided for drugs prescribed for weight loss.

Weight Loss Surgery

Covered:
For benefits to be provided, you will need to obtain pre-authorization and satisfy the criteria for surgery required by the plan as well as follow the physicians program to qualify for surgery. To learn more about the requirements for surgery, contact your medical carrier for details. Benefits are limited to one surgery per lifetime with allowance for adjustments.

Benefits will only be provided if the service is approved by the patient's health plan. The approval is valid for six months from the date of the approval. If the procedure is postponed beyond six months, the patient's health plan will need to evaluate the individual's clinical status to determine if extending the authorization timeframe is appropriate.

Not Covered:
Experimental/Investigational Weight loss surgery and Weight loss surgery that is performed without the necessary pre-authorization, including:

- Roux-en-Y gastric bypass combined with simultaneous gastric banding
- Biliopancreatic diversion (BPD) without duodenal switch (DS)
- Fobi-Pouch (limiting proximal gastric pouch)
- Gastric electrical stimulation (GES) or gastric pacing
- Gastroplasty (stomach stapling)
- Intestinal bypass
- Intragastric balloon
- Loop gastric bypass
- Mini-gastric bypass
- Vagus nerve blocking or stimulation
- Endolumenal surgery

Patients with one of the following contraindications may not be eligible for receiving the surgery:

- Severe Heart Failure
- End stage chronic lung disease
- Unstable angina (CAD)
- End stage liver disease with cirrhosis and portal hypertension
- Cancer (active under treatment or diagnosis)
- Active substance abuse/dependency (drug or alcohol)
- Major untreated psychiatric problems
- Severely impaired intellectual capacity
- Active pregnancy
- HIV/AIDs

See Also:
Surgery earlier in this section.

Wigs or Hair Pieces

Covered:
Wigs and hair pieces will be covered but only when related to hair loss resulting from medical treatment, such as Chemotherapy treatment. Coverage will be limited to one wig per year.

Not Covered:
Benefits shall not be provided for wigs and hair pieces for cosmetic purposes due to baldness or thinning of the hair, unless Medically Necessary due to medical treatment, such as for hair loss caused by Chemotherapy treatments for cancer.

See Also:
Chemotherapy Treatments earlier in this section.

X-Ray and Laboratory Services

Covered:
Tests, screenings, imaging, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, standard edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

See Also:
Diagnostic Services earlier in this section.
Inpatient Hospital Care earlier in this section.
Outpatient Hospital Care earlier in this section.
Preventive or Wellness Care earlier in this section.

CHI Wellness Program

Employees and Dependents enrolled in the Medical Plan are eligible to participate in the CHI Wellness Program.

CHI partners with Virgin Pulse to provide the CHI Wellness Program. As a part of the CHI Wellness Program, you will have access to tools to better understand your health condition, such as the online Personal Health Assessment, and resources including certified health coaches and advisors to help you manage and reduce health risks through encouragement to take action, where necessary.

CHI funds the full amount necessary to provide benefits under the Wellness Program. CHI shall have the option to provide incentives for participation in the program. Any incentive will be in the form and amount selected by CHI. The form of incentive can include, but is not limited to, gift cards, premium discounts, reductions in a Deductible or Copay under the medical plan, cash payments or contributions to another arrangement (such as the Health Savings Account). The form and amount of any available incentive shall be communicated to participants annually.

For details about the CHI Wellness Program, visit the *well-being* pages found on InsideCHI at **http://home.catholichealth.net/wellbeing** or call the HR/Payroll Connection Support Center at 1-844-450-9450.

Notice
Your health plan is committed to helping you achieve your best health. Incentives for participating in the Wellness Program are available to all employees in the Medical Plan. If you think you might be unable to meet a standard for an incentive under this wellness program, you might qualify for an opportunity to earn the same incentive by different means. Contact Virgin Pulse at 888-671-9395, and they will work with you (and, if you wish, with your doctor) to find a wellness program with the same incentive that is right for you in light of your health status.

Weight Watchers

CHI has partnered with Weight Watchers to provide this proven weight-loss approach at a reduced cost. The program is available to employees and spouses eligible under the CHI Wellness Program.

Weight Watchers gives you more flexibility and freedom than ever before. Their new WW Freestyle™ program makes deciding what to eat much easier. It encourages you to move for pleasure (not just because you should) and it gives you the skills to help you think differently about yourself.

Y**ou have three ways to participate, based on your needs:** In-person meetings, OnlinePlus, and Weight Watchers for Diabetes.

If you're eligible, CHI will cover a portion of your monthly membership fees.

To learn more or to enroll, go to **https://wellness.weightwatchers.com**
Employer ID: 14346820

Weight Watchers Enrollment Assistance Customer Service Number: 866-204-2885.

Please note that the amount paid by CHI is taxable. You will be taxed on that amount on your paychecks.

General Conditions of Coverage, Exclusions, and Limitations

The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services, supplies, devices, and drugs mentioned in this Summary Plan Description (SPD).

General Conditions of Coverage

Medically Necessary
A key general condition for the Plan to pay Benefits is that the service, supply, device, or drug must be Medically Necessary and meet acceptable standards of medical and/or dental practices. Even a service, supply, device or drug listed as otherwise covered in *The Details — What's Covered and Not Covered* section of this SPD may be excluded if it is not Medically Necessary. The Claims Administrator determines whether a service, supply, device, or drug is Medically Necessary. Even though a Provider may recommend a service or supply, it may not necessarily be Medically Necessary.

A Medically Necessary health care service is one that a Provider, exercising prudent clinical judgment, provides to a patient for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Accidental Injury, disease, or its symptoms, and is:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
- Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and
- Physician Specialty Society recommendations and the views of Physicians practicing in the relevant clinical area; and
- Any other relevant factors; and
- Clinically appropriate in terms, type, frequency, extent, site, and duration, and considered effective for the patient's Illness, Accidental Injury, or disease; and
- Not provided primarily for the convenience of the patient, Physician, or other health care Provider.

Alternative Services, Supplies, Devices, or Drugs
An alternative service, supply, device, or drug may meet the criteria of Medical Necessity for a specific Condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, the Plan reserves the right to approve the least costly alternative.

Meeting Eligibility Requirements
Another general condition of coverage is that the person who receives services must meet the eligibility requirements found in the *Adding or Dropping Coverage* section of this SPD and the *Eligibility Addendum* to this Summary Plan Description.

General Exclusions

Even if a service, supply, device, or drug is listed as otherwise covered in *The Details — What's Covered and Not Covered* section of this SPD, it is not eligible for Benefits if any of the following general exclusions apply:

Investigational, Experimental or Unproven Services
You are not covered for a service, supply, device, or drug that is Investigational, experimental or unproven. A treatment is considered Investigational or experimental when it has progressed to limited human applications but has not achieved recognition as being proven effective in clinical medicine.

To determine Investigational or experimental status, the Claims Administrator may refer to technical criteria established, including whether a service, supply, device, or drug meets these criteria:

- It has final approval from the appropriate governmental regulatory bodies;
- The scientific evidence must permit conclusions concerning its effect on health outcomes;
- It improves the net health outcome;
- It is as beneficial as any established alternatives; and
- The health improvement is attainable outside the Investigational settings.

While the Claims Administrator may rely on these criteria, the final decision remains at the discretion of the Plan Administrator.

Fees for Non-Medical Services
You are not covered for telephone consultations, fees for providing information concerning a Claim, charges for missed appointments, charges for completion of any form, or any other types of charges or fees for information.

Personal Hygiene, Comfort, and Convenience Items
You are not covered for items used for your personal convenience, such as:

- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of Illness or Accidental Injury (including, but not limited to, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, swimming pools, etc.); or
- Items that do not serve a medical purpose or are not needed to serve a medical purpose.

Provider is a Family Member
You are not covered for a service, supply, device, or drug received from a Provider who is in your immediate family (which includes yourself, Spouse, Legally Domiciled Adult, natural or adoptive parent, Child, sibling, step-parent, step-child, step or half-brother, step or half-sister, mother-in-law, father-in-law, son-in-law, daughter-in-law, sister-in-law, brother-in-law, grandparent, grandchild, Spouse of a grandparent, or Spouse of a grandchild).

No Payment Obligation
You are not covered for a service, supply, device, or drug for which you are not required to make payment or would have no legal obligation to pay if you did not have this Plan or similar coverage.

Covered by Other Programs or Laws
You are not covered for a service, supply, device, or drug if:

- You are entitled to Claim Benefits from a governmental program (other than Medicaid);
- Someone else has the legal obligation to pay for services and without this Plan, you would not be charged;
- Prescription Drug Claims submitted to the medical program Claims Administrator that were not paid by the Prescription Drug Program Claims Administrator (including amounts unpaid by the Prescription Drug Program Claims Administrator for Coinsurance and Copayments);

- Medical Claims submitted to the Prescription Drug Program Claims Administrator that were not paid by the medical program Claims Administrator (including amounts unpaid by the medical program Claims Administrator for Deductibles, Coinsurance and Copayments); and
- Services, supplies, devices, or drugs you require for an Illness or Accidental Injury sustained while on active military duty.
- Services, supplies, devices, or drugs you require for an Illness or Accidental Injury sustained while incarcerated.

Services Not Mentioned
You are not covered for any service, supply, or device that is not specifically mentioned in this SPD.

Acts of War
You are not covered for any services, supplies, devices, or drugs for any Illness or Accidental Injury occurring on or after your Coverage Date that results from war or an act of war.

Illegal Acts
Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation, by committing or attempting to commit any crime, criminal act, assault, or other felonious behavior, or by participating in a riot or public disturbance.

Workers' Compensation
You are not covered for services, supplies, devices, or drugs that are compensated under workers' compensation laws, including services, supplies, devices, or drugs applied toward satisfaction of any Deductible under your Employer's workers' compensation coverage. You are also not covered for any services, supplies, devices, or drugs that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of Claims, and medical treatment authorization.

Benefit Limitations

Benefit limitations refer to amounts for which you are responsible under this Plan. These amounts are not credited toward your Out-of-Pocket Maximum. In addition to the exclusions and conditions described earlier in this section, the following are examples of Benefit limitations and your financial responsibilities under this Plan:

- A service, supply, device or drug that is not covered under this Plan is your responsibility;
- If a Spouse, parent, and/or Child are covered separately under this Plan, Benefits will not be duplicated;
- If a Covered Service, supply, device, or drug reaches a service or prescription maximum, it is no longer eligible for Benefits (a maximum may renew at the next Benefit Year). See *The Details — What's Covered and Not Covered* section of this SPD;
- If you receive total Benefits in an amount that reaches a Benefit or lifetime maximum, you are no longer eligible for Benefits under this Plan. See *Highlights of the Medical Plan Options, Quick Reference — What's Covered and Not Covered, What You Pay — A Tutorial,* and *The Details — What's Covered and Not Covered* sections of this SPD;
- If you do not obtain pre-notification for medical services, supplies, devices, or drugs, Benefits can be reduced or denied. You are responsible for these Benefit reductions only if you are responsible (not your Provider) for notification. An In-Network Provider may handle notification

requirements for you. See *Medical and Pharmacy Notification Requirements and Care Coordination;*

- If you do not obtain Prior Authorization or follow Step Therapy requirements for certain Prescription Drugs, Benefits can be reduced or denied. You are responsible for any reduction in Benefits or the cost of the denied drug. See *Medical and Pharmacy Notification Requirements and Care Coordination;* and
- The type of Provider you choose can affect your Benefits or what you pay. See *What you Pay — A Tutorial* and *Network Details — Choosing a Provider* sections of this SPD.

Network Details — Choosing a Provider

Choosing Your Medical Providers

Each medical plan option under the Catholic Health Initiatives (CHI) Medical Plan has three levels of Benefits based on the type of Provider you use — Enhanced (clinically integrated network) Providers, In-Network (Blue Cross Blue Shield network) Providers and Out-of-Network Providers. You will receive the highest level of Benefits within the Enhanced network.

Enhanced Network Providers
If you use a provider within the Enhanced network, you will pay a lower out-of-pocket Coinsurance amount than you would for other Providers.

To determine if a local clinically integrated network facility or provider is in the Enhanced network, call the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card or log on to your medical Claims Administrator's Web site.

In-Network Providers
The Plan relies on a network, which consists of Providers that have negotiated reduced rates for specific services. When these Providers offer services to you, they will not bill you for any difference between their negotiated rates (their Eligible Charges) and their standard rates. This results in lower out-of-pocket expenses for you, since the Plan will pay a higher Coinsurance level and your Deductible will be lower than if you used an Out-of-Network Provider.

To determine if a Provider is an In-Network Provider, ask your Provider, call the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card, or log on to your medical Claims Administrator's Web site. See the *Who to Contact With Questions* section of this Summary Plan Description for the Web address.

If you are receiving Emergency Services, an Out-of-Network Provider will be treated as an In-Network Provider for the Emergency Services you receive. Once your Condition stabilizes, the Out-of-Network Provider will cease to be treated as an In-Network Provider under this Plan.

Out-of-Network Providers
The Plan will also cover Out-of-Network Providers, but you will have a higher Deductible and the Plan will pay a lower Coinsurance level. You will typically pay the most for services received from them. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services.

If you require services from a Specialist and an In-Network Provider is not available within a 50-mile radius, of your home address, you may utilize an Out-of-Network Specialist who has expertise in diagnosing and treating your Condition. The Claims Administrator must approve Out-of-Network Specialist services before you receive the services. Even after you receive approval, you are still responsible for complying with any notification requirements of this Plan. See the *Medical and Pharmacy Notification Requirements and Care Coordination* section of this SPD.

The Three Levels of Benefits Available to You

There are three types of providers and the amount you will pay out-of-pocket will vary depending on the type of provider you use.

1. **Use of an Enhanced (clinically integrated network) Provider**
   The charges billed by Providers within the Enhanced network will be reimbursed at the highest percentage available under the Plan. You will not be billed for charges above the negotiated "Eligible Charge" if the negotiated Eligible Charge is less than the actual Billed Amount.

2. **Use of an In-Network (Blue Cross Blue Shield National PPO Network) Provider**
   When you go to an In-Network Provider, you will not be billed for charges above the negotiated "Eligible Charge" if the negotiated Eligible Charge is less than the actual Billed Amount.

   You will be reimbursed at a higher percentage than if you had gone to an Out-of-Network Provider but at a lower percentage than if you had gone to an Enhanced Network Provider. If the services rendered are subject to the Deductible and the Deductible has not been met, these charges will be applied to the Deductible.

3. **Use of an Out-of-Network Provider**
   If you incur charges from an Out-of-Network Provider, the Deductible will be higher and you will be reimbursed at the lowest Coinsurance percentage level.

   Costs for services received from an Out-of-Network provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges. You may be billed for the difference between the Medicare allowable rate and the provider's billed charges.

Choosing a Pharmacy

When you are being treated for an Illness or Accidental Injury, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage under the Medical Plan includes Benefits for Prescription Drugs. You can have your prescriptions filled at a CHI-owned pharmacy (if available), CVS network retail Pharmacy, CHI-owned pharmacy mail order/90 Day Fill (if available) or through the CVS/Caremark mail-order Pharmacy. The Prescription Drug Benefits are administered by a different Claims Administrator than your medical Benefits. For specific Copayment and Coinsurance amounts, see the *Highlights of the Medical Plan Options* section of this Summary Plan Description (SPD).

Retail Pharmacy
You will save the most money by filling your prescription at a CHI-owned pharmacy (if available). CHI also chose to offer the Pharmacy Claims Administrator's broadest network of retail Pharmacies. You are urged to check with your Pharmacy before filling a prescription to make certain that your Pharmacy is an In-Network Provider, or you may contact the Pharmacy Claims Administrator's customer service number on the back of your ID card or utilize the pharmacy locator on their website.

To find out if your Pharmacy is an In-Network Provider or to find an In-Network Provider Pharmacy near you, ask your Pharmacist, call the CHI Medical Plan Customer Service Team at the number on the back of your ID card or log on to the Pharmacy Web site. See the *Who to Contact With Questions* section of this Summary Plan Description for the Web address.

You may have your prescriptions filled at the Pharmacy of your choice, but your Benefits will be maximized when you use a CHI-owned Pharmacy or a Network Pharmacy, as described below:

- When you have your prescription filled at a CHI-owned Pharmacy, you will pay 50 percent less than you would from a Network Pharmacy.
- When you have your prescription filled at an In-Network Provider Pharmacy, you must pay a Copayment or Coinsurance amount for each prescription; however
- When you have your prescription filled at an Out-of-Network Provider Pharmacy, the Benefit will pay the Out-of-Network Coinsurance level of the Claims Administrator's discounted amount for that drug; you will be responsible for the remaining cost.

You can receive up to a 30-day supply of your medication at a retail Pharmacy or a 90-day supply at a CHI-owned Pharmacy.

Mail-Order Pharmacy

You may also use the CHI-owned mail-order Pharmacy (if available) or the CVS/Caremark mail-order Pharmacy. Maintenance prescriptions (for example, blood pressure medications) must be filled using the CVS/Caremark mail-order Pharmacy or a CHI-owned Pharmacy. You can receive up to a 90-day supply of your medication through mail-order or a CHI-owned pharmacy. Mail-order prescriptions are mailed to your home or another mailing address of your choice.

Medical and Pharmacy Notification Requirements and Care Coordination

Your Medical Care

Pre-Notification
You must call the CHI Medical Plan Customer Service Team at the number found on the back of your ID card to pre-certify the following services prior to receiving care:

- Inpatient Hospital stays;
- Room and Board for Residential Treatment;
- Private Duty Nursing Services;
- Skilled Nursing Services/Extended Care Facilities;
- Home Health Care;
- Transplants;
- Mental Health/Chemical Dependency Hospital stays (Inpatient and Partial Hospitalization Treatment Programs) and
- Weight Loss Surgery.

The following services must be pre-certified within two business days of Admission:

- Emergency Inpatient Hospital stays; and
- Maternity stays.

When you pre-certify, you should be prepared to provide the following information:

- The name of the attending and/or admitting Physician;
- The name of the Hospital where the Admission has been scheduled and/or the location where the service has been scheduled;
- The scheduled Admission and/or service date; and
- A preliminary diagnosis or reason for the Admission and/or service.

Failure to call the CHI Medical Plan Customer Service Team or failure to comply with the determinations of the Plan will result in a $500 penalty in addition to any applicable Deductibles, Copayments and/or Coinsurance as described in this SPD. The $500 penalty does not apply for failure to pre-certify Maternity stays, which fall under the applicable 48-hour or 96-hour time frame (see *Maternity Services* under *The Details — What's Covered and What's Not* section of this SPD), or failure to pre-certify in situations where pre-notification is either impossible or would result in jeopardy to the life or health of the Claimant.

Completing the Plan's Pre-notification requirements or simply calling the CHI Medical Plan Customer Service Team before obtaining a service acts as notice to the Plan that you are obtaining specific services, but it does **not** result in a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, Conditions, (including Medical Necessity), limitations, and exclusions of the Medical Plan. The decision of whether or not to receive care is between you and your Provider.

Length of Stay/Service Review
Your pre-notification notice information will be analyzed by the Plan. The Plan will review the information and any additional information they may request from you or your Provider to determine the appropriate length of stay/service for the stay/service that you have requested.

A letter will be sent by the Plan to you, your Physician and/or Hospital informing them of the appropriate length of stay/service for the stay/service you have requested.

If the Plan determines that no length of stay/service is appropriate, the Plan will notify you of its adverse Benefit determination in accordance with Notice of Adverse Benefit Determinations under the Appealing a Denied Medical or Pharmacy Claim section of this SPD.

Except in the case of human organ transplants, the initial length of stay/service review will not include an advance review of whether or not the underlying procedure/service is Medically Necessary. The Plan will not make its determination as to whether the underlying procedure/service is Medically Necessary until after the underlying procedure/service has been completed.

Prior Approval for Procedures/Services

The Plan will, upon request, review a proposed procedure/service for coverage under the Plan, including Medical Necessity, and give you "prior approval" before the procedure/ service is rendered. If you do not seek prior approval before undergoing a particular procedure/service, the Plan will review whether the procedure/service was properly covered under the Plan, after the fact, and if it is determined that the procedure/service was not covered by the Plan, you may be required to pay for it yourself.

You can obtain prior approval by calling the CHI Medical Plan Customer Service Team prior to Admission or the performance of services in an Outpatient setting. You should be prepared to provide the following information:

- The name of the attending and/or admitting Physician;
- The name or description of the planned service;
- The preliminary diagnosis or reason for the Admission and/or service;
- The name of the Hospital where the Admission has been scheduled and/or the location where the service has been scheduled; and
- Scheduled Admission and/or service date.

The Plan will review the medical information provided and may follow up with your Provider to determine whether the services to be rendered are Medically Necessary and otherwise covered under the Plan.

After reviewing the request, the Plan will notify you and your Provider of the decision.

- If your request is approved, you will know that the Medical Plan covers the specific services or procedures; and
- If Benefits are denied, you will receive written notice and the denial notice will list the reason(s) for denial. This notice will be mailed to the most current addresses the Plan has on record for you and your Provider.

Certain factors may alter or impact whether you receive approval. These factors include Medical Necessity, Benefit Plan provisions, and the dates you receive services.

Benefits for the approved service are limited to the Benefits described in this SPD if they are in effect for the patient on the date services are provided.

In an Emergency or Medically Urgent Situation, the Plan will respond to a request for prior approval of health services within 24 hours of the request. In non-Urgent situations, the Plan will respond to such a request within 15 days. You may appeal a denial as explained later in the *Appealing a Denied Medical or Pharmacy Claim* section of this SPD.

Condition Management Program

The condition management program, managed by your clinically integrated network (CIN), helps employees and their dependents who are enrolled in a Medical Plan to manage chronic conditions and improve their overall health and quality of life. The chronic conditions maintained through the program include asthma, COPD (emphysema or chronic bronchitis), coronary artery disease, diabetes, heart failure, high blood pressure and high cholesterol.

This free, voluntary program is completely confidential and provides in-depth and personalized support to help employees make the best possible health decisions. Participants have access to a personal nurse advocate, a registered nurse who has extensive experience with the chronic condition. In partnership with the participant's physician, the nurse advocate consults with the participant over the phone to assess the participant's health, review care, discuss other medical concerns and develop a holistic plan for improving the employee's overall well-being. Participation in the condition management program, while highly encouraged, is not mandatory.

Diabetes Care Program

Taking care of yourself and your diabetes is important to your health. The CVS/Caremark and Livongo Transform Diabetes Program, provided at no cost to you as part of the CHI Medical Plan, offers you specialized resources and extra benefits to make managing your diabetes easier:

- The Livongo connected meter, provided at no cost to you, helps you keep track of your glucose levels. This meter automatically sends your numbers to a secure online account after each test, eliminating log books and making it easier to share with your doctor or anyone you choose. You'll also get personalized guidance from certified Diabetes Educators any time you want a little extra support.

  With the Livongo meter, you can:
  - Track your levels, see trends and share your data with whomever you choose.
  - Get unlimited test strips and lancets delivered to your door with no out-of-pocket cost.
  - Get personalized tips in real time to help you stay on track and make informed choices.

- Help prevent diabetes-related conditions with two diabetes monitoring visits per year at any CVS MinuteClinic® location. These visits include:
  - A1c testing
  - Foot exams
  - Body mass index (BMI) assessment
  - Diet consultation
  - Blood pressure check
  - Cholesterol screening

There's no out-of-pocket cost to you and no appointment needed for these visits.

- Take advantage of personalized one-on-one coaching with a pharmacist to manage your diabetes medication. Stop in a CHI pharmacy (where available) or a CVS pharmacy, or call the number on your member ID card to speak with a CVS/Caremark pharmacist.

- Save on Diabetes and other health items at CVS Pharmacy and Target.

To get started, visit **start.livongo.com** or call the Livongo Team at 800-945-4355. Use registration code: CHI

Obtaining Prescriptions

Prior Authorization
The Medical Plan requires that you go through the Prior Authorization process to obtain coverage for certain Prescription Drugs. Prior Authorization is the process whereby a Pharmacist employed by the Claims Administrator approves the usage and duration of a medication. A partial list of medications that require Prior Authorization can be found below.

Your Pharmacist will inform you if the prescribed medication needs to be pre-authorized. The Pharmacist may initiate the review process, or you may request that your Physician call a toll-free phone number that will be supplied by your Pharmacist. You (or your Physician or Pharmacist) will be notified within 72 hours of the Plan's receipt of the Claim. If your medication is authorized, you will pay the applicable Copayment or Coinsurance. If your medication is not approved for coverage under the Plan, you will pay the full cost of the drug. Also, the Plan will notify you of its adverse Benefit determination in accordance with *Notice of Adverse Benefit Determinations* under the *Appealing a Denied Medical or Pharmacy Claim* section of this SPD.

Drugs that require Prior Authorization include but are not limited to:
- Some cancer agents;
- Attention deficit disorder and hyperactivity medications;
- Rheumatoid arthritis medications; and
- Specialty medications.

This list is not intended to be all-inclusive and may be updated periodically.

Drug Utilization Review
Under the Drug Utilization Review program, prescriptions filled at the retail Pharmacy and processed on-line or through the mail service Pharmacy are examined for potential drug interactions based on your personal medication profile. A drug interaction occurs when certain drugs act together to result in an adverse effect on the body. The Drug Utilization Review is especially important if you or your covered Dependents take many different medications or see more than one doctor. If there is a question about your prescription, your Pharmacist may contact your Physician before dispensing the medication.

Step Therapy Program
This Plan uses a tool called Step Therapy, which requires you to first try one or more specified drugs to treat a particular Condition before the Plan will cover another (usually more expensive) drug that your doctor may have prescribed. Step Therapy is intended to reduce costs to you and the Plan by encouraging use of medications that are less expensive but can still treat your Condition effectively.

Some drugs that require Step Therapy include but are not limited to:

- Hypnotics (sleep aids);
- Migraine headache medications; and
- Proton pump inhibitors (ulcer medications).

This list is not intended to be all-inclusive and may be updated periodically.

If you are taking a medication that requires Step Therapy, the Plan will not cover that medication unless you first try the alternative (less expensive) medication. If your doctor believes you should take the original medication, your doctor can request a coverage review. If a coverage review is requested, and your Physician provides a valid clinical reason for not prescribing the alternative drug, you may purchase the originally prescribed medication at the appropriate Coinsurance. If your physician does not provide a valid clinical reason, you have the option to purchase the original medication at the full cost of the drug, or you can purchase the preferred alternative at the appropriate Copayment or Coinsurance.

Medical and Pharmacy Claims Procedures

Your Medical Claims

In order to obtain your Benefits under this Plan, it is necessary for a Claim to be filed with the Claims Administrator. To file a Claim, typically all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. However, it is your responsibility to ensure that the necessary Claim information has been provided to the Plan.

Once the Plan receives your Claim, it will be processed and the Benefit payment will usually be sent directly to the Hospital or Physician. You will receive an explanation of Benefits statement telling you how much was paid. In some cases, the Claims Administrator will send the payment directly to you, or, if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Plan's records.

Typically, you do not have to file a Claim if you use a CHI or In-Network Provider. However, in certain situations, you will have to file your own Claim, particularly if you receive care from an Out-of-Network Provider. To find out how to file a Claim, contact the CHI Medical Plan Customer Service Team. They will provide you with Claim forms and detailed instructions.

Claims must be filed with the Claims Administrator, either by you or the Provider, on or before 12 months following the date on which your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment.

Pre-Service Claims (Prospective Review)
If you submit a Pre-Service Claim, you will be notified of the Plan's determination within 15 days of the receipt of the Claim by the Plan, unless the Plan needs an extension due to matters beyond control of the Plan and notifies you before the expiration of the initial 15-day period. The notification will include an explanation of the circumstances requiring the extension and the date by which the Plan expects to render a decision. The extension will be no longer than 15 days — that is, 30 days from the receipt of the Claim.

However, if the Plan needs an extension due to your failure to submit complete information, then the Plan will notify you of the specific information needed within 15 days of receipt of your Claim. You will have 45 days from receipt of the notice to provide the specified information.

Any notification of adverse Benefit determination will be made in accordance with *Notification of Adverse Benefit Determination*s under the *Appealing a Denied Medical or Pharmacy Claim* section of this SPD.

Pre-Service Claims That Are Urgent in Nature
If you submit a Pre-Service Claim that is urgent, you will be notified of the Plan's determination within 72 hours of the Plan's receipt of the Claim. Thus, in some instances, you may not receive notification prior to your scheduled date of treatment/ Admission. If you provide insufficient information for the Plan to make a determination, the Plan will notify you within 24 hours of receipt of the Claim. You will then have 48 hours to provide the missing information. The Plan will notify you of its Benefit determination within 48 hours of receiving the missing information or within 48 hours of when the information should have been provided, whichever is earlier.

Before an adverse determination may be made by the Plan, a Physician employed by the Claims Administrator will automatically review your Claim. If, after a Physician's review, an adverse determination is made, the Plan will notify you in accordance with Notification of Adverse Benefit Determinations under the Appealing a Denied Medical or Pharmacy Claim section of this SPD. However, the Plan may notify you verbally in order to comply with the 72-hour deadline discussed above. In that event, the Plan will send a written or electronic notification within three days of the verbal notification.

Post-Service Claims
If you submit a Post-Service Claim, you will be notified of the Plan's determination within 30 days of the receipt of the Claim by the Plan, unless the Plan needs an extension due to matters beyond control of the Plan and notifies you before the expiration of the initial 30-day period. The notification will include an explanation of the circumstances requiring the extension, and the date by which the Plan expects to render a decision. The extension will be no longer than 15 days—that is, 45 days from the receipt of the Claim.

However, if the Plan needs an extension due to your failure to submit complete information, then the Plan will notify you of the specific information needed within 30 days of receipt of your Claim. You will have 45 days from receipt of the notice to provide the specified information. Otherwise, your Claim may be denied.

Any notification of adverse Benefit determination will be made in accordance with *Notification of Adverse Benefit Determinations* under the *Appealing a denied Medical or Pharmacy Claim* section of this SPD.

Payments Made in Error
If for any reason a payment is made in error, the Plan retains the right to recover the amount paid.

When Hospitalized on Your Coverage Effective Date
If you, or your enrolled Dependent, are admitted to the Hospital as an Inpatient prior to your Coverage Date, and continue to be hospitalized through your Coverage Date, the Hospital Facility Charges for that confinement will not be covered under this Plan. However, charges for Professional Provider services related to your confinement that are incurred on or after your Coverage Date will be considered for Claim Payment provided they are for Covered Services.

When Hospitalized on Your Coverage End Date
If you, or your enrolled Dependent, are admitted to the Hospital as an Inpatient prior to your coverage end date and continue to be hospitalized through your coverage end date, the Hospital Facility Charges will be covered until you are discharged from the Hospital. However, charges for Professional Provider services related to your confinement that are incurred after your coverage end date will not be covered.

Your Prescription Claims

Retail Pharmacy Claims
You can receive up to a 30-day supply of your medication at a retail Pharmacy. The Copayments or Coinsurance for retail Pharmacy prescriptions are summarized in the *Highlights of the Medical Plan Options* section of this SPD.

The Copayments or Coinsurance for diabetic supplies purchased at a retail Pharmacy are as follows:

- Any combination of insulin and diabetic supplies purchased on the same day are subject to one Copayment or the applicable Coinsurance amount.
- Additional Copayments or applicable Coinsurance amounts will apply to any combination of supplies (lancets, test strips, etc.) purchased separately from an insulin purchase.

Mail-Order Pharmacy Claims

You can receive up to a 90-day supply of your medication at a mail-order Pharmacy or CHI-owned retail/mail pharmacy (if available). The Copayments or Coinsurance for mail-order Pharmacy prescriptions are summarized in the *Highlights of the Medical Plan Options* section of this SPD.

The Copayments or Coinsurance for diabetic supplies purchased through the mail are as follows:

- Any combination of insulin and diabetic supplies purchased on the same day are subject to one Copayment or the applicable Coinsurance amount.
- Additional Copayments or applicable Coinsurance amounts will apply to any combination of supplies (lancets, test strips, etc.) purchased separately from an insulin purchase.

Benefits of Using the Mail-Order Pharmacy

Example below assumes the Deductible has been met for the Integrated HDHP/HSA option and the prescription is not filled at a CHI-owned Pharmacy. Keep in mind, if the Deductible wasn't met, you could use your Health Savings Account dollars to help pay for the full price of the prescription. Also, if you use a CHI-owned Pharmacy, the cost savings to you would double.

	Generic Drug	Brand Formulary	Brand Non-Formulary
Integrated Core			
3-month supply at Retail Pharmacy	$30	$120 to $330	$195 to $480
3-month supply by Mail Order	$25	$100 to $175	$160 to $325
Savings	**$5**	**$20 to $155**	**$35 to $155**
Integrated Basic			
3-month supply at Retail Pharmacy	$30	$120 to $330	$195 to $480
3-month supply by Mail Order	$25	$100 to $175	$160 to $325
Savings	**$5**	**$20 to $155**	**$35 to $155**
Integrated HDHP/HSA – after deductible is met			
3-month supply at Retail Pharmacy	$30	$120 to $330	$195 to $480
3-month supply by Mail Order	$25	$100 to $175	$160 to $325
Savings	**$5**	**$20 to $155**	**$35 to $155**

The CHI Prescription Plan Formulary

The Prescription Drug portion of the Medical Plan utilizes a Formulary. A Formulary is a list of preferred drugs that have been selected based on safety, clinical effectiveness and cost effectiveness. A committee of doctors and Pharmacists reviews the Formulary quarterly. You may purchase any covered drug, but you will pay a lower Coinsurance if you purchase drugs that are included on the

Formulary. To find out if your medication is on the CHI Prescription Plan Formulary, call CVS/Caremark at 1-877-232-7925 or log on to www.caremark.com. See the *Who to Contact With Questions* section of this SPD.

Generic and Brand Name Drugs
All Prescription Drugs available for coverage under the Medical Plan are either Brand Name Drugs or Generic Drugs. Brand Name Drugs have the product names under which the drug is advertised and sold. Generic Drugs are sold under generic, often unfamiliar names, yet by law they must have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their Brand Name counterparts. You will pay a Copayment for a Generic Drug, and your out-of-pocket payment will be less.

Keep in mind, if you fill a brand-name prescription when there is a generic equivalent available, you will pay the brand-name prescription coinsurance ***plus*** the difference between the generic and brand-name amount. If it is medically necessary for you to have the brand-name prescription, your doctor can contact CVS/Caremark to get an exception so you don't pay more for the brand-name prescription.

How to Fill Retail Prescriptions At In-Network Pharmacies
Simply present your Medical Plan ID card and prescription(s) to the Pharmacist. The Claims Administrator's computerized system will confirm your eligibility for Benefits. The Pharmacist will tell you the Copayment or Coinsurance amount you are required to pay. You do not have to file a Claim form for prescriptions filled at a network Pharmacy.

How to Fill Retail Prescriptions At Out-of-Network Pharmacies
Submit a completed Claim form to the Claims Administrator. The prescription receipt must be attached to the form. To obtain Claim forms, log on to www.caremark.com. (See *Who to Contact With Questions*) or call CVS/Caremark at 1-877-232-7925 and use the automated ordering system.

- You must pay the full prescription price at the time of purchase
- You will be reimbursed within approximately 21 days of the Plan's receipt of your Claim form. The amount you receive will be based on the amount you would have been charged by an In-Network Pharmacy, minus the required Coinsurance amount.

How to Fill New Mail-Order Prescriptions
Ask your doctor to prescribe your medication for up to a 90-day supply plus refills (if appropriate). Mail your prescription and required Copayment or Coinsurance along with an order form in the envelope provided in your mail-order welcome kit or take the prescription to your local CHI-owned Pharmacy (if available). You may make payment by check or credit card. To confirm the correct Copayment or Coinsurance amount, contact CVS/Caremark at 1-877-232-7925 or log on to www.caremark.com. You will receive your prescription(s) within 7-14 days at the address you indicate for delivery.

Refilling Your Mail-Order Prescriptions

You can reorder on or after the refill date indicated on the refill slip you receive with your first order, or on your medication container. Or reorder when you have less than 14 days of medication left. You can refill your prescription on-line at www.caremark.com, by contacting the CHI-owned Pharmacy where the prescription was filled (See *Who to Contact With Questions*) or by calling the CVS/Caremark at 1-877-232-7925.

Prescription Drug Dose Optimization
The dose optimization program helps your Physicians and Pharmacists provide the most effective and cost-efficient medication regimens. The program is designed to simplify taking prescription medications by consolidating doses.

Many prescription medications are available in a variety of strengths and can be taken safely in a single dose once a day, rather than several smaller doses throughout the day. By taking a single dose, fewer doses of the medication are required and it is more cost effective. A Pharmacist that is employed by the Claims Administrator will contact your Physician to discuss if dose optimization is right for you. Your Physician will be consulted before any change is made to your prescription.

Prescription Drug Quantity Limitations
Some medications are covered only in certain quantities. In addition, the covered quantity amount may be limited to certain time periods. The limits on these medications are based on treatment guidelines that are considered reasonable, safe, and effective. However, in cases where your prescription exceeds the quantity limit and additional quantities might be Medically Necessary, your Physician must provide additional medical information to the Plan to determine whether the particular circumstances meet the criteria for additional quantities.

Coordination of Your Benefits with Other Plans and Responsible Parties

Benefits for Medicare Eligible Covered Persons
This section describes the Benefits which will be provided for Medicare Eligible Covered Persons who are not affected by Medicare Secondary Payer (MSP) laws, (see *Medicare Eligible Persons and Their Enrollment in This Plan* and *Your Medicare Secondary Payer (MSP) Responsibilities* under the *Adding or Dropping Coverage* section of this SPD).

The Benefits and provisions described throughout this Summary Plan Description (SPD) apply to Medicare Eligible Covered Persons. The process used in determining Benefits under the Medical Plan is as follows:

- Determine what the payment for a Covered Service with provisions of the Plan; and
- Process and make payment based on the type of service received and benefit level of the provider.

Coordination of Benefits
Coordination of Benefits (COB) applies when you or your Dependents have health care coverage through more than one group program. The intent of COB is to provide that the sum of Benefits paid under the Medical Plan plus Benefits paid under all other plans will not exceed the actual cost charged for treatment. If the Medical Plan Benefit amount is greater than the primary carrier's payment, the Medical Plan will pay the difference between its Benefit and the primary carrier's payment. If it is less than or equal to the primary carrier's payment, the Medical Plan will pay nothing. It is your obligation to notify the CHI Medical Plan Customer Service Team of the existence of such other Group Coverage.

To coordinate Benefits, it is necessary to determine what the payment responsibility is for each Benefit program.

This is done by following the rules below:

- The coverage under which the patient is the Eligible Person (rather than a Dependent) is primary, meaning: full Benefits are paid under that program. The other coverage is secondary and only pays any remaining Eligible Charges up to the Benefits available under that program.
- When a Dependent Child receives services and the Child is covered under more than one parent's health care plan, the birthdays of the Child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
    - However, when the parents are separated or divorced and the parent with custody of the Child has not remarried, the Benefits of a program which covers the Child as a Dependent of the parent with custody of the Child will be determined before the Benefits of a program which covers the Child as a Dependent of the parent without custody;
    - When the parents are divorced and the parent with custody of the Child has remarried, the Benefits of a program which covers the Child as a Dependent of the parent with custody will

be determined before the Benefits of a program which covers that Child as a Dependent of the step-parent, and the Benefits of a program which covers that Child as a Dependent of the stepparent will be determined before the Benefits of a contract which covers that Child as a Dependent of the parent without custody; and

- Notwithstanding the items above, if there is a court decree which would otherwise establish Financial Responsibility for the medical, dental, or other health care expenses with respect to the Child, the Benefits of a program which covers the Child as a Dependent of the parent with such Financial Responsibility shall be determined before the Benefits of any other program which covers the Child as a Dependent Child. It is the obligation of the person claiming Benefits to notify the Medical Plan, and upon its request to provide a copy of such court decree.

- If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group Benefit program does not include a COB provision. In that case, the other group program is automatically primary.

Additionally, in the case of the removal of impacted wisdom teeth or for oral Surgery, a patient's dental plan (if any, and if the above procedure is listed as a covered Benefit under that plan) will always be primary, and the Medical Plan will be secondary. If there is no dental coverage, the Medical Plan will be primary.

The Medical Plan has the right in administering these COB provisions to:

- Pay any other organization an amount which it determines to be warranted if payments which should have been made by the Medical Plan have been made by such other organization under any other group program; and
- Recover any overpayment which the Medical Plan may have made to you, any Provider, insurance company, person or other organization.

In order to prevent duplicate payment of Benefits for a Claim, the Medical Plan uses the following process to determine Benefits when it is the secondary payor:

- Determine what the Benefit for services would be under the provisions of the Medical Plan; and
- Deduct from this resulting amount the amount paid by the primary payor. The difference is the Benefit that will be paid under the Medical Plan.

Rights to Reduction, Reimbursement, and Subrogation

The Medical Plan has the right to:

- Reduce or deny Benefits otherwise payable by the Medical Plan; and
- Recover or subrogate 100 percent of the Benefits paid by or to be paid by the Medical Plan for covered persons to the extent of any and all of the following payments:
  - Any judgment, settlement or payment made or to be made because of an Accident, including but not limited to other insurance;
  - Any auto or recreational vehicle insurance coverage or Benefits including but not limited to uninsured/ underinsured motorist coverage;
  - Any personal umbrella coverage;
  - Any medical payments coverage, no fault automobile coverage or any first party insurance coverage;
  - Business and homeowners medical and/or liability insurance coverage or payments;

- Workers' Compensation coverage;
- Attorney's fees; and
- Any other coverage available for your illness or injury.

Subrogation
The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

Reimbursement
If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Cooperation Required
The Catholic Health Initiatives Medical Plan requires covered persons or their representatives to cooperate in order to guarantee reimbursement to the Medical Plan from any other party Benefits. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. Failure to comply with this request will entitle the Plan to withhold Benefits due to covered persons under the Medical Plan. Covered persons or their representatives may not do anything to hinder reimbursement of overpayment to the Medical Plan after you have accepted Benefits.

All attorney's fees and court costs are the responsibility of the Participant, not the Medical Plan.

These rights apply regardless of whether such payments are designated as payment for, but not limited to:

- Pain and suffering;
- Medical Benefits;
- Other specified damages; or

- Whether the Participant has been made whole (i.e., duly compensated for his/her injuries).

The Plan has the right to file suit on your behalf for the Condition related to the medical expenses to recover Benefits paid or to be paid by the Medical Plan.

Additional Provisions

The following provisions also apply:

- If you reside in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the Medical Plan is secondary. The Medical Plan will reduce Benefits for an amount equal to, but not less than, the state's mandatory minimum personal injury protection or medical payment requirement;
- The Medical Plan has first priority with respect to its right to reduction, reimbursement and subrogation;
- The Medical Plan is secondary to any excess insurance policy, including but not limited to, school and/or athletic policies;
- The Medical Plan has the right to reduce or withhold future Benefits payments for Claims filed for covered persons;
- The Medical Plan will not pay for future medical charges because of the Accident until medical charges have exceeded all amounts that were recovered, or are to be recovered by or on behalf of the covered person;
- The provisions described in the *Rights to Reduction, Reimbursement, and Subrogation* under this section of the SPD apply to you and all of your covered Dependents;
- The Medical Plan has the right to recover interest on the amount paid out by the Plan because of the Accident;
- The Medical Plan has the right to recover the amount paid out because of the Accident in a lump sum;
- The Medical Plan is not subject to any state law doctrines, including but not limited to the common fund doctrine, which would purport to require the Medical Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs;
- The Plan does not pay for nor is responsible for the covered person's attorney's fees. Attorney's fees are to be paid solely by the covered person;
- The right of reduction, reimbursement, and subrogation is based on the language in the Summary Plan Description in effect at the time of judgment, payment or settlement;
- The Medical Plan's right of reduction, reimbursement and subrogation applies to any funds recovered from another party by or on behalf of the estate of any covered person; and
- The Medical Plan's right to first priority shall not be reduced due to the Eligible Person's own negligence.
- By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan;
- Further, the Plan will automatically have a lien to the extent of Benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid Benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the Plan;

- In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Interpretation and Jurisdiction
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such Benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such Benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Your Responsibility Regarding Right of Reduction and/or Recovery
To aid the Medical Plan in its enforcement of its right of reduction, recovery, reimbursement and subrogation, the Eligible Person and his/her representative must, at the Medical Plan's request and at its discretion:

- Take any action;
- Give information; and
- Execute documents so required by the Medical Plan.

Failure to aid and comply with such requests may result in the Medical Plan withholding or recovering Benefits, services, payments or credits due or paid under the Medical Plan.

The Medical Plan's right to reimbursement occurs when the Medical Plan pays your charges relating to an Accident while waiting for any party to make payment to you or to someone else on your behalf. Reimbursement to the Medical Plan of 100 percent of these charges shall be made at the time the payment is received by you, your attorney or other person on your behalf.

Appealing an Eligibility Claim

If you are denied a Benefit under the Plan due to questions regarding your eligibility or entitlement for coverage under the Plan or regarding the amount you owe, you may request a review upon written application to the Plan Administrator.

You, or your authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and if review is requested, to prepare for such review.

An appeal of an adverse benefits determination must be made in writing within 90 days upon receipt of the notice that the claim was denied. If an appeal is not made within the above referenced timeframe, all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. A written appeal should include: written description of the reason for the appeal, written comments, additional documents and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Plan Administrator, within a reasonable time, but no later than 90 days after receipt of the request for review, will decide the appeal. Any medical expert consulted in connection with the appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of any medical expert consulted in connection with the appeal will be provided upon request. Once a decision is reached, a letter providing notice of the decision will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information. If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

Appealing a Denied Medical or Pharmacy Claim

Notification of Adverse Benefits Determinations

If the Plan makes an adverse Benefit determination, you will receive a written or electronic notice from the Plan with:

- Specific reasons for denial;
- Reference to the Plan provisions on which the denial is based;
- Description of additional information which may be necessary to clarify your Claim and an explanation as to why the information is necessary;
- Explanation of how you may have the Claim reviewed, including applicable time limits and a statement of your right to bring a civil action following an adverse determination or review. Please note, however, that civil action will not be an option until the first mandatory appeal is completed. Also, if a specific internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the Plan will provide a copy of the rule, guideline, protocol, or other similar criterion or a statement will be provided stating that such an item was used in making the determination and that a copy of it will be sent upon request.

If the adverse determination is based on a Medical Necessity exclusion, Investigational or experimental treatment exclusion, or a similar exclusion or limit, then an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances will be provided, or a statement will be provided stating that such analysis will be provided upon request. If you receive an adverse determination concerning a Claim for an Emergency or Medically Urgent Situation, you will also receive a description of the expedited review process available for such a Claim.

Appeal Process for Medical Claims

If you have questions regarding coverage or how a Claim will be paid, you should call the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card. If, after your Claim is processed, you question the payment of a Claim, you may submit an appeal for review. The appeals process varies slightly depending on whether the Claim is for Prescription Drug Benefits or for other Benefits within the Plan. The Prescription Drug Benefit appeals process is described later in this section. See *Appeal Process for Prescription Drug Claims.*

The review process will be conducted by someone different from the original decision makers and without deference to the original decision. If a decision requires medical judgment, an appropriate medical expert will be consulted who was not previously involved in your case. If the decision on an appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

Post-Service Claim Appeals Process

Before beginning the appeals process, you may wish to call the CHI Medical Plan Customer Service Team. They may be able to assist you. However, any communication and/or correspondence exchanged with the Customer Service Team will not affect your appeals deadlines as set forth in this Summary Plan Description. You must comply with these deadlines.

STEP ONE – Appeal to the Claims Administrator
If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure:

- Notify the Claims Administrator of the reasons why you do not agree with the denial or partial denial;
- Provide any clinical documentation from your Physician that would substantiate coverage of the denied Claim;
- Include the following information:
  - Name;
  - Address;
  - Daytime Phone Number;
  - Group and ID Number; and
  - Provider Name and Date of Service; and
- File the Claim within 180 days after you receive notice of a denial or partial denial by submitting the appeal to the Claims Administrator either in writing or by calling the CHI Medical Plan Customer Service Team.

Written appeals should be sent by U.S. mail to:

The CHI Medical Plan
Blue Cross Blue Shield of Illinois
Attn: Appeals Department
3405 Liberty Drive
Springfield, IL 62704

You may designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

When you are preparing your appeal, you and/or your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial.

The Claims Administrator will give you a written decision within 60 days after it receives your request for review. The receipt of the Claims Administrator's written decision marks the end of your official appeal. If the determination is unfavorable to you, you may submit a voluntary request for review to the Medical Plan Administrator, as discussed below.

STEP TWO – Voluntary Request for Review
If the appealed claim is again denied, you may file a second appeal with the Claims Administrator. The denial notice will specify the timeframe for filing a second appeal (typically 60 days from receipt of the denial notice). You also have the right to request without charge, copies of any document, record or other information submitted, considered, generated or used in making the decision.

Notice of the second appeals decision will be sent to you within 60 days of receipt of the appeal.

If your appeal is denied, you may have the right to file a request for an external review of the adverse benefits determination. A denial, reduction, termination or failure to provide a benefit based on a determination that a participant or beneficiary fails to meet the eligibility requirements under the terms

of the Plan is not eligible for external review. Please contact the Claims Administrator for additional information on requesting an external review.

You must exhaust your appeal rights under the Plan before bringing any legal action with respect to a claim for benefits under the Plan. In addition, any such action must be brought within 12 months from the date on which you submitted your claim or the date the claim was required to be submitted, whichever is earlier.

Pre-Service Claim Appeals Process

If you have a pre-service request that has been denied, you are entitled to an expedited review process. Start your expedited review appeal by calling the CHI Medical Plan Customer Service Team. They may be able to assist you. However, any communication and/or correspondence exchanged with the Customer Service team will not affect your appeals deadlines as set forth in this Summary Plan Description. You must comply with these deadlines.

STEP ONE – Appeal to the Claims Administrator
Within 180 days after you receive notice of a denial or partial denial, you may submit an appeal to the Claims Administrator either in writing or by calling the CHI Medical Plan Customer Service Team. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. You should include any clinical documentation from your Physician that would substantiate coverage of the denied Claim. The appeal must include the following information:

- Name;
- Address;
- Daytime Phone Number;
- Group and ID Number; and
- Provider Name and Date of Service.

Written appeals should be sent by U.S. mail to the same address listed above under *Post-Service Claim Appeals Process* for step one appeals to the Claims Administrator.

You may designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

When you are preparing your appeal, you and/or your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial.

Medically Urgent Pre-Notification Request
If you seek pre-notification for a Medically Urgent Situation and receive an adverse Benefit determination, you are entitled to a review of the adverse determination within 72 hours of the Claims Administrator's receipt of your appeal. If the resolution of your official Medically Urgent Situation pre-notification request appeal is unfavorable to you, then you may submit a voluntary request for review to the Claims Administrator. If you have exhausted your appeal rights, you may pursue legal remedies.

Non-Urgent Pre-Service Requests
If you seek a non-Urgent pre-service request and receive an adverse Benefit determination, you are entitled to a review of the adverse determination within 30 days of the Claims Administrator's receipt of your request for appeal. If the resolution of your official Pre-Service Claim appeal is unfavorable to you, then you may submit a voluntary request for review to the Claims Administrator. If you have exhausted your appeal rights, you may pursue legal remedies.

If the determination is unfavorable to you, you may submit a voluntary request for review to the Medical Plan Administrator, as discussed later in this section.

STEP TWO – Voluntary Request for Review for Both Pre-Service and Post-Service Claims
If the appealed claim is again denied, you may file a second appeal with the Claims Administrator. The denial notice will specify the timeframe for filing a second appeal (typically 60 days from receipt of the denial notice). You also have the right to request without charge, copies of any document, record or other information submitted, considered, generated or used in making the decision.

Notice of the second appeals decision will be sent to you within 60 days of receipt of the appeal.

If your appeal is denied, you may have the right to file a request for an external review of the adverse benefits determination. A denial, reduction, termination or failure to provide a benefit based on a determination that a participant or beneficiary fails to meet the eligibility requirements under the terms of the Plan is not eligible for external review. Please contact the Claims Administrator for additional information on requesting an external review.

You must exhaust your appeal rights under the Plan before bringing any legal action with respect to a claim for benefits under the Plan. In addition, any such action must be brought within 12 months from the date on which you submitted your claim or the date the claim was required to be submitted, whichever is earlier.

External Review

"External Review" is a review of an eligible adverse benefit determination or a final internal adverse benefit determination by an independent review organization/external review organization (ERO) or by the State Insurance Commissioner, if applicable. A "final external review decision" is a determination by an ERO at the conclusion of an external review.

You must complete all of the levels of standard appeal described above before you can request external review, other than in a case of deemed exhaustion. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You may file a voluntary appeal for external review of any adverse benefit determination or any final internal adverse benefit determination that qualifies as set forth below.

The notice of adverse benefit determination or final internal adverse benefit determination that you receive will describe the process to follow if you wish to pursue an external review.

You must submit the request for external review within 180 calendar days of the date you received the adverse benefit determination or final internal adverse benefit determination notice. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day

that is not a Saturday, Sunday or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary, and you are not required to undertake it before pursuing legal action. If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review
The external review process under this Plan gives you the opportunity to receive review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to applicable law. Your request will be eligible for external review if the claim decision involves medical judgment and the following are satisfied:

- The Plan, or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An adverse benefit determination based upon your eligibility is not eligible for external review. If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, the medical plan administrator and the Plan unless otherwise allowed by law.

Appeal Process for Prescription Drug Claims

If Prior Authorization of your Prescription Drug is denied, use the following steps:

STEP ONE – Initial Appeal to the Claims Administrator
Within 180 days after you receive notice of a denial or partial denial, forward your appeal to the Claims Administrator. The appeal must be in writing and must include the following information:

- Name;
- Address;
- Daytime Phone Number;
- Group and ID Number
- Provider Name and Date of Service
- A clear statement that the communication is intended to appeal an Adverse Benefit Determination or Adverse Coverage Determination

The appeal should be sent by U.S. mail to:

CVS Caremark
Appeals Dept. – MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084

Or fax toll-free to 1-866-443-1172.

You may designate a representative to act for you in the review process. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

When you are preparing your appeal, you and/or your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial.

The Claims Administrator will give you a written decision within 30 days after it receives your request for review.

Expedited Review Processes Available for Pre-Notification Claims
If you seek review of a Medically Urgent Situation Claim or Pre-Service Claim that has been denied, and you do not purchase the drug due to its expense, then you are entitled to an expedited pre-service review within 30 days of the Claims Administrator receiving your Claim.

Use the same procedures set forth above in the Appeal Process for Prescription Drug Claims section above.

Medically Urgent Situation Claims
If you seek Prior Authorization for a Prescription Drug that is needed urgently and your request for Prior Authorization is denied, the Claims Administrator will review the adverse determination within 72 hours of their receipt of your request for review. If the resolution of your official Medically Urgent Situation Claim appeal is unfavorable to you, then you may submit a voluntary request for review to the Claims Administrator. If you have exhausted your appeal rights, you may pursue legal remedies.

Pre-Service Claims
If you seek Prior Authorization for a drug, you are denied, and you do not purchase the drug due to its expense, then you are entitled to an expedited pre-service review within 15 days of the Claims Administrator receiving your Claim. Additionally, your second request for review by the Claims Administrator will also be completed within 15 days of their receipt of your second request for review. If the resolution of your official Pre-Service Claim appeal is unfavorable to you, then you may submit a voluntary request for review to the Claims Administrator. If you have exhausted your appeal rights, you may pursue legal remedies.

Termination of Coverage and Coverage Continuation

Termination of Coverage

Coverage under this plan will cease on the last day of the month in which one or more of the following occur:

- You no longer meet the description of an Eligible Person;
- The Catholic Health Initiatives Medical Plan terminates; or
- Your Dependent ceases to be eligible for enrollment as a covered Dependent under the rules set forth in the *Adding or Dropping Coverage* and *Glossary of Terms* sections of this Summary Plan Description (SPD).

No Benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Plan, except as otherwise specifically stated in the *Continuation of Coverage (COBRA)* section below. However, termination of your coverage under the Medical Plan shall not affect any Claim for Covered Services rendered prior to the Effective Date of such termination.

If one of your Dependents becomes ineligible, his or her coverage will end as of the last day of the month in which the Qualified Status Change occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).

Options available for continuation of coverage are explained in the *Continuation of Coverage (COBRA)* section below.

Severance Pay

For benefits-eligible employees, benefits continue through the end of the month following your last day of employment. The following benefits can continue via COBRA for eighteen months:

- Medical Plan
- Dental Plan
- Vision Plan

Employees who receive a severance payout can apply for continuation of the above benefits through COBRA at the active employee premium rate for the first three (3) months of the severance period regardless of their length of severance period. After the first three (3) months of COBRA coverage, all severed employees will be required to pay the full COBRA cost (102% of the premium) if they need additional time for health coverage. Participation in the EAP plan is extended to the employee and family members at no cost while participating in COBRA benefits.

Continuation of Coverage (COBRA)

The purpose of this section of the Summary Plan Description is to explain the options which are required under the Consolidated Omnibus Budget Reconciliation Act of 1985 which is a federal law for temporarily continuing your coverage at group rates in certain instances when your coverage would otherwise end.

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA**

continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description (SPD) or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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/Legally Domiciled Adult 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 are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

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

- Your Spouse/Legally Domiciled Adult dies;
- Your Spouse/Legally Domiciled Adult's hours of employment are reduced;
- Your Spouse/Legally Domiciled Adult's employment ends for any reason other than his or her gross misconduct;
- Your Spouse/Legally Domiciled Adult 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 any of the following qualifying events happens:

- 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 becomes entitled to Medicare Benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child is no longer eligible for coverage under the Plan as a "Dependent Child."

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee becoming entitled to Medicare Benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For other qualifying events (such as: divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the contact provided at the end of this section.

Notification of a qualifying event to the Plan Administrator must include the following information:

- Name and identification number of the Member and each qualified beneficiary;
- Type and date of initial or second qualifying event; and
- Name, address and daytime phone number of the qualified person (or legal representative) that the Plan Administrator may contact if additional information is needed to determine COBRA rights.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee becoming entitled to Medicare Benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare Benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement.

For Example: If a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA continuation coverage for his or her Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.
Disability Extension of 18-Month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator within 60 days of the Social Security Administration's decision (and before the end of the original 18-month period of

COBRA continuation coverage), you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To request an extension of your continuation coverage due to disability, send a copy of any letters from the Social Security Administration and the Notice of Determination to the contact provided at the end of this section.

Your request must also include the following:

- Name and identification number of the member and each qualified beneficiary;
- Type and date of initial or second qualifying event;
- Phone number of the qualified person (or legal representative) that the Plan Administrator may contact if additional information is needed to determine COBRA rights.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare Benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Determining Your Contributions for Continuation Coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36-month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29-month period, contributions for coverage during the extended disability period may never exceed 150 percent of the plan costs.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at http://www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA Contact Information

Discovery Benefits
P.O. Box 2079
Omaha, NE
68108-2079
1-866-451-3399

Family Medical Leave (FMLA)
If CHI grants you an approved family or medical leave (approved FMLA leave) leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by CHI.

If CHI grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue health Benefits for you and your eligible Dependents. At the time you request the leave, you must agree to make any required contributions to continue coverage.

If any coverage CHI allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date CHI determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues. However, health coverage may be available to you under another plan sponsored by CHI.

Any coverage being continued for a Dependent will not be continued beyond the date it would otherwise terminate.

If Benefits terminate because your approved FMLA leave is deemed terminated, you may, on the date of such termination, be eligible for continuation under federal law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined Dependent), you (or your eligible Dependents) may be eligible for such continuation on the date CHI determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new Dependent while your coverage is continued during an approved FMLA leave, the Dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for CHI following the date CHI determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date CHI determines the approved FMLA leave to be terminated. If you

do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because CHI determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date CHI determines the approved FMLA leave is terminated.

General Plan Provisions and Your Rights Under ERISA

Group Benefit Plan Notice of Privacy Practices

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Catholic Health Initiatives (CHI) health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Prescription Drug, Dental, Vision, EAP, Flexible Benefits and Wellness plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you
The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not *CHI* as an employer — that's the way the HIPAA rules work. Different policies may apply to other CHI programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information
The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you. Further, the Plan may use your health information to contact you to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you. For example, if you are diagnosed or treated for conditions related to high- blood pressure, we may contact you to inform you of available treatment options for that medical condition and where you could access a health care provider to ensure your health care is being properly managed.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For

example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Note that such programs and activities may be provided by and/or be administered through organizations or entities that are affiliated with CHI, such as Clinically Integrated Network (CIN), if such organization or entity has entered into an agreement to provide such services to the Plan. Such affiliated organizations and entities may use and disclose your health information received from the Plan; however, they are only permitted to use health information disclosed to it for the purposes of providing the services for which they were retained by the Plan, and as described in this Notice. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses private health information (PHI) for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information

The Plan, or its health insurer or CIN, may disclose your health information without your written authorization to CHI for plan administration purposes. CHI may need your health information to administer benefits under the Plan. CHI agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The CHI benefits team within Human Resources is the only CHI employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and CHI, as allowed under the HIPAA rules:

- The Plan, or its insurer or CIN, may disclose "summary health information" to CHI, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or CIN, may disclose to CHI information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that CHI cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by CHI from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

State law may further limit the permissible ways the Plans use or disclose your health information. If an applicable state law imposes stricter restrictions on the Plans, we will comply with that state law.

Other allowable uses or disclosures of your health information
In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule
Business Associates	Disclosures to the Plan's third-party business associates (e.g., a health insurance broker/consultant, wellness coordinator, claims billing organization, etc.) that perform activities or services on behalf of the Plan. Each business associate must agree in writing to protect the confidentiality of your medical information.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. Certain types of medical information have additional protection under state or federal law. For instance, information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, we are required to get your permission before disclosing it to others in many circumstances. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear,

conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete
With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below. You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time. The Catholic Health Initiative Notice of Health Information Privacy Practices is available to you upon your request and may be obtained by writing to:

Catholic Health Initiatives
Attn: HR Operations
3900 Olympic Boulevard, Suite 400
Erlanger, KY 41018-1099

You also may obtain a copy of this notice online by visiting the *well-being* pages found on InsideCHI at **http://home.catholichealth.net/wellbeing**.

Right to Receive Notice of a Breach
You have the right to be notified in writing following a breach of your health information that is not secured in accordance with certain security standards.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice either through mail to your home address on file or online by visiting the *well-being* pages found on InsideCHI at**http://home.catholichealth.net/wellbeing**.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of the U.S. Department of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, please visit the following website to file a complaint online or to obtain a Health Information Privacy Complaint form that can be printed and mailed to the regional Office for Civil Rights, Department of Health & Human Services.

www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Contact
For more information on the Plan's privacy policies or your rights under HIPAA, contact*:*

Director Corporate Responsibility Resources
Privacy Officer
Catholic Health Initiatives
188 Inverness Drive West, Suite 800
Englewood CO 80112

Additional contacts

The following is a list of keypersons or offices you may need to contact to exercise your rights under the HIPAA privacy rule for different benefit plans offered by CHI:

	Restricted disclosures	Confidential communications	Access to or copies of your health information	Amendment of your health information	Accounting of disclosures
Medical Plan – Blue Cross Blue Shield of Illinois	Director, Privacy Office Blue Cross Blue Shield of Illinois P.O. Box 804836 Chicago, IL 60680-4110 Phone: 877-361-7594 (or see back of ID card) Website: http//www.bcbsil.com/important_info/hipaa.html				
Medical Plan – Anthem (CHI Saint Joseph Health & KentuckyOne Health)	Privacy Office OH0101-C300 4361 Irwin Simpson Road Mason, OH 45040 Phone: Call member services on the back of your ID card Email WellPoint's Privacy Office: Privacy.Office@WellPoint.com				
Medical Plan – Wellmark (Mercy Iowa)	Wellmark, Inc. Privacy Office, Station 5W590 1331 Grand Avenue Des Moines IA 50309-2901 Phone: 877-610-6395 Email: privacyoffice@wellmark.com Website: www.wellmark.com				
Medical Plan – Blue Cross Blue Shield of South Carolina (CHI Health)	Privacy Office Blue Cross Blue Shield of South Carolina I-20 East at Alpine Road (AC-200) Columbia, SC, 29219 Phone: 803-264-7258				
Medical Plan – Cigna (Texas)	Privacy Office Cigna Medical Group CIGNA HealthCare of Arizona 25500 N. Norterra Dr. Phoenix, AZ 85085 Phone: 602-906-2800H				
Medical Plan – QualChoice Health Plan Services, Inc. (Arkansas)	QualChoice Health Plan Services, Inc. ATTN: Privacy Official P.O. Box 25610 Little Rock, AR 72221 Phone: 501-228-7111, ext. 5126				
Medical Plan – Zenith (Highline SEIU)	Zenith American Solutions Attn: Tonya Osborne 11724 NE 195th Street #300 Bothell, WA 98011 P: 206-284-4828 VoIP 474828 C: 206-200-6731 tosborne@zenith-american.com				
Prescription Drug Plan – Caremark	CVS Caremark Privacy Office - Investigations & Incident Response team CVS Caremark P.O. Box 52072 Phoenix, AZ 85072-2072				
Dental Plan – MetLife	MetLife Privacy Office P. O. Box 489 Warwick, RI 02887-9954 privacy@metlife.com				

Vision Plan – EyeMed	Privacy Office EyeMed Vision Care, LLC 4000 Luxottica Place Mason, Ohio 45040 Phone: 513-765-4321 Email: privacyoffice@eyemedvisioncare.com Website: www.eyemedvisioncare.com
Employee Assistance Program (EAP) – Beacon Health Options	Phone: Call member services number 877-679-3819
Health Account Administrator – HealthEquity	Phone: Call member services number 866-212-4634
Wellness Plan – Virgin Pulse	The Virgin Pulse Data Protection Officer Virgin Pulse 75 Fountain Street, Suite 310 Providence, RI 02902 Email: privacyofficer@virginpulse.com

Important Plan Information

Plan Sponsor

Catholic Health Initiatives
3900 Olympic Boulevard, Suite 400
Erlanger, KY 41018-1099

Employer Identification Number

47-0617373

Plan Administrator

Catholic Health Initiatives
3900 Olympic Boulevard, Suite 400
Erlanger, KY 41018-1099

Plan Administrator's Authority
The Plan Administrator shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right and power to interpret the Plan and to decide all matters arising under the Plan, including eligibility for Benefits and the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator with respect to any matter relating to the administration of the Plan shall be conclusive and binding on all persons.

The Plan Administrator shall have the following additional powers and duties:

- To require any person to furnish such reasonable information as it may request for the proper administration of the Plan as a condition to receiving any Benefits under the Plan;
- To make and enforce such rules and regulations and prescribe the use of such forms as it shall deem necessary for the efficient administration of the Plan;
- To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan;
- To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, and to provide a full and fair review to any Participant whose Claim for Benefits has been denied in whole or in part;
- To designate other persons to carry out any duty or power which would otherwise be a responsibility of the Plan Administrator under the terms of the Plan; and
- To interpret Plan terms and provisions.

Delegation by the Plan Administrator
The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the administration of Claims or other operations of the Plan. The Plan Administrator and any person to whom any duty or power in connection with the operation of the Plan is delegated may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Employees who are actuaries or accountants), consultant (internal medical director, ombudsman with clinical background, etc.), third party administration service Provider, legal counsel, or other Specialist.

Payment of Administrative Expenses
All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third party administrative service Provider, actuary, consultant, accountant, Specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer.

Funding Policy
The Employer shall fund this Plan out of its general assets. However, the Employer shall also have the right to, in the future, enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type which may become payable under any such insurance contract, to the extent allocable to contributions made by the Employer, shall not be assets of the Plan but shall be the property of and shall be retained by the Employer.

Type of Plan

Welfare Benefit Plan

Plan Number

513

Type of Plan Administration

Employer Administered

Claim Administration

Claims for **medical** Benefits should be directed to:
Blue Cross Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

Claims for the **Health Savings Account** should be directed to:
HealthEquity, Inc.
15 W. Scenic Pointe Dr., Suite 400
Draper, UT 84020

Agent for Service of Legal Process

General Counsel for Catholic Health Initiatives
1999 Broadway
Suite 2605
Denver, CO 80202

Eligibility
Varies by Market-Based Organization or facility

Minimum Maternity Benefits
Group health plans and health insurance issuers offering group insurance coverage, generally may not, under Federal law restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of the above periods.

Loss of Benefits
The provisions regarding termination of coverage and limitations and exclusions of Benefits that may result in reduction or loss of Benefits are explained in this Summary Plan Description.

Contributions
Varies by Market-Based Organization or facility

Funding Arrangements
General assets

Plan Year
The twelve-month period from January 1 to December 31. Your individual Benefit Plan Year may be different depending on your MBO or facility. (See definition of Benefit Plan Year.)

Future of the Plan
Although Catholic Health Initiatives intends to continue the Plan indefinitely, Catholic Health Initiatives reserves the right to amend or end the Plan at any time for any reason. Changes may be made retroactively, if necessary, to qualify or maintain the Benefits under the Internal Revenue Code or the Employee Retirement Income Security Act of 1974 (ERISA). If the plan is amended or ends, you and other active members may not receive Benefits as described in this booklet. However, you may be entitled to receive different Benefits, or Benefits under different conditions. In no event will you become entitled to any vested rights under this Plan.

Statement of ERISA Rights
As a Participant in the Catholic Health Initiatives Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to the following rights:

Receive Information about Your Plan and Benefits

You may examine, free of charge, all documents governing the Plan including insurance contracts, collective bargaining agreements and the latest annual report (Form 5500 Series). These documents are available at the Plan Administrator's office. The annual report also is filed with the U.S. Department of Labor and is available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain copies of all documents governing the operation of the Plan, including updated Summary Plan Descriptions by writing to the Plan Administrator. .

You may also receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
You may continue health care coverage for yourself, your Spouse, or your Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description for the rules governing your COBRA continuation coverage rights.

If you have Creditable Coverage from another plan, you will receive a Certificate of Creditable Coverage that helps to reduce or eliminate exclusionary periods of coverage for Pre-Existing Conditions under your new group health plan. You will be provided a Certificate of Creditable Coverage, free of charge, from Blue Cross Blue Shield:

- When you lose coverage under the plan
- When you become entitled to elect COBRA continuation coverage, or
- When your COBRA continuation coverage ends.

You may also request a Certificate of Creditable Coverage before your coverage ends, or for up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for operating the plan. These people are called "fiduciaries" of the plan. They have a duty to act prudently and in the interest of you and other plan Participants and beneficiaries.

No one, including your Employer or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a Benefit to which you are otherwise entitled or from exercising your rights under ERISA.

Enforcement of Your Rights
If your Claim for a Benefit is denied or ignored, in whole or in part, the Plan Administrator must give you a written explanation of the reason for the denial, and you can obtain copies of documents relating to the decision, without charge. You also have the right to have the Plan Administrator review and reconsider your Claim, all within certain defined time schedules.

Under ERISA, there are steps you can take to ensure the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a

federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If your Claim for Benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. You may also file suit in a federal court if you disagree with a decision, or the lack of a decision, concerning the qualified status of a domestic relations order or medical Child support order. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your Claim is frivolous), it may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about this plan, you should contact the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or contact the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Glossary of Terms

The definitions in this section are terms that are written in capital letters and are used in various sections throughout this Summary Plan Description and have a specific meaning when applied to your health care coverage. When you come across these terms while reading this SPD, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your Benefits. If a term within a definition begins with a capital letter, it means that the term is also defined in these definitions. All definitions have been arranged in alphabetical order. A term that appears in only one section may be defined within that section rather than within this *Glossary of Terms.*

Accident or Accidental Injury…means an accidental bodily injury that is not related to any Illness.

Acupuncture…means the technique of passing long, thin needles through the skin to specific points on the body for treatment of certain Conditions.

Acupuncturist…means a duly licensed acupuncturist.

Admission…means formal acceptance as a patient to a Hospital or other covered facility for a health Condition.

Affordable Care Act (ACA) Preventive Care Drugs…means certain preventive care drugs, as defined by the United States Preventive Services Task Force which are covered 100 percent by the Medical Plan, when prescribed by a physician:

- Aspirin – limited to persons age 45 through 79 years
- Bowel Preparation for Colonoscopy Screening – limited to persons age 49 to 76 years
- Fluoride – limited to persons through the age of 5 years
- Folic Acid – limited to females through the age of 55 years
- Iron – limited to persons less than 1 year of age
- Vitamin D – limited to persons 65 or older

Ambulance…means any licensed land, air, or water vehicle designated, constructed, or equipped for and used for transporting persons in need of medical or surgical attention.

Ambulance Transportation…means local transportation in a specially-equipped certified vehicle from your home, scene of Accident or medical Emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility, or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary services.

Ambulatory Surgical Facility…means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

Anesthesia Services…means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

Annual Enrollment…means the period specified by CHI during which you may elect or change coverage for you and your eligible Dependents.

Applied Behavior Analysis Therapy…means therapy used to improve or change specific behaviors. Applied Behavior Analysis therapy focuses on the principles that explain how learning takes place. Positive reinforcement is one such principle. When a behavior is followed by some sort of reward, the behavior is more likely to be repeated. Applied behavior analysis is the use of techniques and principles to bring about meaningful and positive change in behavior.

Benefit Year…means the period in which your Deductibles, Coinsurance maximums and other Benefit maximums accrue. When you first enroll in the Catholic Health Initiatives (CHI) Medical Plan, your first Benefit Year begins on your Coverage Date and ends on December 31 of that year. On subsequent years, your Benefit Year will be the 12-month period from January 1 to December 31.

Benefits…mean Medically Necessary Covered Services or Supplies that qualify for payment under this Plan.

Billed Amount…means the amount that a Provider bills for a service or supply, or the retail price that a Pharmacy charges for a Prescription Drug, whether or not it is covered under this Plan.

Birth Center…means a duly licensed facility, institution or place where births are planned to occur following a normal, uncomplicated, low-risk pregnancy.

Brand Name Drug…means a drug item which is under the patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies.

Breach…means the unauthorized acquisition, access, use, or disclosure of Unsecured PHI which compromises the security or privacy of such information. For purposes of this definition, "compromises the security or privacy of such information" means poses a significant risk of financial, reputational, or other harm to the individual who is the subject of the PHI. A use or disclosure of a Limited Data Set, that also excludes date of birth and zip code, does not compromise the security and privacy of PHI. Breach excludes:

- Any unintentional acquisition, access, or use of PHI by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by HIPAA.
- Any inadvertent disclosure by a person who is authorized to access PHI at a Covered Entity or Business Associate to another person authorized to access PHI at the same Covered Entity or Business Associate, or Organized Health Care Arrangement in which the Covered Entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.
- A disclosure of PHI where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Business Associate…means any third-party, other than the Plan Sponsor or Plan Sponsor personnel, who receives, uses, or discloses Protected Health Information in connection with the performance of an administrative function on behalf of the Plan or the Organized Health care Arrangement, or in connection with the provision of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or on behalf of the Plan or the Organized Health Care Arrangement, within the meaning of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, 21 CFR Parts 160 and 164 ("HHS Reg."), §160.103.

Catholic Health Initiatives or **CHI**…means Catholic Health Initiatives and its Market-Based Organizations (MBOs).

CHI Facility…means a Hospital or other health care facility which is fully or partially owned by Catholic Health Initiatives (CHI).

Certificate of Credible Coverage…means a certificate disclosing information relating to your Credible Coverage under a health care Benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

Certified Clinical Nurse Specialist…means a duly licensed certified clinical nurse Specialist.

Certified Nurse-Midwife…means a duly licensed certified nurse-midwife.

Certified Nurse Practitioner…means a duly licensed certified nurse practitioner.

Certified Registered Nurse Anesthetist or CRNA…means a duly licensed certified nurse anesthetist.

Chemical Dependency…means substance abuse or dependence on drugs and/or alcohol, including abuse of Prescription Drugs.

Chemotherapy…means the treatment of malignant Conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Child…means:

- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an Eligible Person by birth, marriage, legal adoption, or placement for adoption who is under the age of 26; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an Eligible Person by birth, marriage, legal adoption, or placement for adoption who is under the age of 26 for whom the eligible Person is required by law to provide health coverage; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, under the age of 26 of an eligible Legally Domiciled Adult; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, under the age of 26 who resides primarily in the Eligible Person's household and for whom the Eligible Person is the Legal Guardian, such as a court approved foster child; or
- A dependent (within the meaning of Code § 105(b)) unmarried child of the Eligible Person by birth, marriage, legal adoption, or placement for adoption who is age 26 or over, who is

dependent upon the Eligible Person for support and maintenance because of a continuous developmental or physical disability that began prior to the date the dependent attained age 26 and:

- The disabled dependent was covered by this Plan or other group medical insurance coverage as a disabled dependent prior to reaching age 26.
- If enrolling for the first time, the disabled dependent who is 26 years of age or older of a newly Eligible Person may be enrolled for coverage if the Eligible Person enrolls during the initial eligibility period and provides proof that the dependent satisfies the foregoing requirements within 31 days of the initial date of eligibility.
- The Plan may request documentation of the dependent's continued disability on an annual basis. The disabled dependent shall be eligible for coverage so long as the dependent continues to be disabled, unless coverage otherwise terminates under the Plan.
- The disabled dependent must be continuously covered under the Plan in order to maintain eligibility.

Chiropractor…means a duly licensed chiropractor.

Claim…means notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Billed Amount, and any other information which the Claims Administrator may request in connection with services rendered to you.

Claims Administrator…means Blue Cross Blue Shield of Illinois for medical claims and CVS/Caremark for Prescription Drug claims.

Claim Payment…means the Benefit payment calculated by the Claims Administrator, after submission of a Claim, in accordance with the Benefits described in this SPD. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

Clinical Laboratory…means a duly licensed clinical laboratory.

Clinical Professional Counselor…means a duly licensed clinical professional counselor.

Clinical Social Worker…means a duly licensed clinical social worker.

Clinically Integrated Network (CIN)… means a network of providers, facilities and ancillary services collaborating to improve the health of their patients. For purposes of this Summary Plan Description, the following local CINs are considered an Enhanced network: Rainier Health Network

COBRA…means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an Employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

Coinsurance…means that you and the Plan share a percentage the Eligible Charge.

Condition…means any disease, Illness, Accident or Accidental Injury, bodily dysfunction, pregnancy, Substance Abuse disorder, or Illness Affecting Mental Health.

Copayment or Copay…means a specified dollar amount that you are required to pay towards a Covered Service.

Coverage Date…means the date on which your coverage under the Catholic Health Initiatives (CHI) Medical Plan begins.

Covered Entity…means a health plan, health care clearinghouse, or a health care Provider who transmits Protected Health Information in electronic form.

Covered Provider…means a Provider covered under this Plan.

Covered Service or Covered Services and Supplies…means a service and/or supply specified in this SPD for which Benefits will be provided.

Credible Coverage…means coverage you had under any of the following:

- A group health plan;
- Health insurance coverage for medical care under any Hospital or medical service policy plan, Hospital, or medical service plan contract, or HMO contract offered by a health insurance insurer;
- Medicare (Parts A or B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act);
- Medical care for members and certain former members of the uniformed services and their Dependents;
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health Benefits risk pool;
- A health plan offered under the Federal Employees' Health Benefits Program;
- A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country;
- A health plan under Section 5(e) of the Peace Corps Act; or
- State Children's Health Insurance Program (Title XXI of the Social Security Act).

Custodial Care Service…means any services primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your Condition. Custodial Care Services also means those services that do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressing, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.). Custodial Care Services also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvements by you.

Deductible… means the amount you have to pay before your Catholic Health Initiatives (CHI) Medical Plan Benefits subject to Coinsurance begin. Integrated Core Plan and Integrated Basic Plan exceptions to the deductible are preventive care services, office visits, coinsurance amounts, CHI

Facility charges and Prescription Drugs. Integrated HDHP/HSA Plan exceptions to the deductible are preventive care services.

Dentist…means a duly licensed Dentist.

Dependent…means your Spouse, an eligible Legally Domiciled Adult and/or Child(ren) as defined in this section of the Summary Plan Description. Only one non-child Dependent can be enrolled.

Diabetes Educator…means a duly licensed person who is legally certified to supervise diabetes Outpatient self-management training and educational services. These services are designed to teach diabetics self-management skills and lifestyle changes to effectively manage diabetes and to avoid complications from diabetes.

Diagnostic Service…means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a Condition, disease or Accidental Injury. Such tests include, but are not limited to, x-rays, pathological services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Dialysis Facility…means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

Dietitian…means a duly licensed dietitian.

Drug Utilization Review (DUR)…means a system-based drug Claims review process which alerts Pharmacists and Physicians to important therapeutic issues regarding the use of medication. By alerting Physicians and Pharmacists to issues, DUR reduces risk and improves the quality of care for the patient and reduces unwarranted costs.

Durable Medical Equipment Provider…means a duly licensed durable medical equipment Provider.

Effective Date…means the first day of coverage under CHI's health plan or the first day following the waiting period.

Eligible Charge…means (a) in the case of a Provider other than a Professional Provider which has a written agreement with the Claims Administrator to provide care to you at the time Covered Services are rendered, such Provider's Billed Amount for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with the Claims Administrator to provide care to you at the time Covered Services are rendered, the amount for Covered Services as determined by the Claims Administrator based on the following order:

- The charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by the Claims Administrator, if available,
- The amount that the Center for Medicare & Medicaid Services (CMS) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program, or
- The charge which the particular Hospital or facility usually charges its patients for Covered Services.

Eligible Person…means an Employee of the Employer who meets the eligibility requirements for this coverage, as described in the *Eligibility* section and the *Eligibility Addendum.*

Embedded... means the individual Deductible and Out-of-Pocket Maximums are included in the family Deductible and Out-of-Pocket Maximums. Family members will accumulate deductible and out-of-pocket maximum amounts until they meet the individual limits listed. The remaining family members will accumulate amounts to meet the family limits. No individual of a family will ever meet the entire family limits.

Emergency or Medically Urgent Situation…means an accidental traumatic bodily injury or other medical Condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Prudent Layperson who possesses an average knowledge of health and medicine to:

- Place a patient's health in serious jeopardy, or with respect to a pregnant woman, place the health of the woman or her unborn Child in serious jeopardy;
- Result in serious impairment to the patient's bodily functions;
- Result in serious dysfunction of a bodily organ or body part; or,

In the opinion of a Physician with knowledge of the patient's medical Condition, would subject the patient to sever pain that cannot be managed without the services in question. With respect to a pregnant woman who is having contractions, an Emergency exists where there is inadequate time to affect a safe transfer to another Hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or unborn Child.

Conditions that require immediate Emergency treatment include, but are not limited to the following:

- Heart attacks;
- Strokes;
- Convulsions;
- Serious burns;
- Bone fractures;
- Wounds requiring sutures (stitches);
- Poisoning;
- Severe chest or abdominal pains;
- Loss of consciousness;
- Major depression with significant suicidal intent;
- Psychosis with associated homicidal intent; and
- Manic episode resulting in inability to care for oneself.

In addition, the service provided must be a Covered Service or Supply, and not one that is normally treated on a non-Emergency basis.

Emergency Accident Care…means the initial Outpatient treatment of accidental injuries which a Prudent Layperson would consider an Emergency including related Diagnostic Services.

Emergency Medical Care…means services provided for the initial Outpatient treatment, including related Diagnostic Services, for a medical Condition, which a Prudent Layperson would consider an Emergency and would reasonably require you to seek immediate medical aid.

Examples of Emergency Medical Conditions are: severe chest pains, convulsions, or persistent severe abdominal pains.

Employee…means an individual employed by the Employer who meets the following requirements:

- Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer, and
- Such individual is determined by the Employer to be an Employee, for purposes of the Employer's payroll records. "Employee" does not include a "Leased Employee," as defined in Code Section 414(n)(2). Only individuals who are paid as Employees from the Employer's payroll and are treated by the Employer as Employees will be considered Employees for purposes of the Plan. Any individual who is treated as an independent contractor by the Employer is not an Employee. Also, an individual who renders services to the Employer pursuant to an agreement between the Employer and a leasing organization, temporary employment agency or any other organization is not an Employee. Any individual who is retroactively or in any other way held or found to be a "statutory" or "common-law" Employee of the Employer will not be eligible to participate in the Plan for any period he or she was not contemporaneously treated as an Employee by the Employer and considered by the Employer to be an Employee. In addition, such an individual will remain ineligible for participation in the Plan unless the Plan is amended to specifically render the individual eligible for Plan participation.

Employer…means Catholic Health Initiatives ("CHI") and any MBOs or facilities/entities listed in the *Eligibility Addendum*. Where the context requires it, the term CHI will also mean Employer.

Employment Status…means any of the following events that affect the eligibility of you, your Spouse of your Dependent:

- Termination or commencement of employment with CHI;
- Strike or lockout;
- Commencement of or return from an unpaid leave of absence; and
- Change in worksite.

ERISA…means the Employee Retirement Income Security Act of 1974. ERISA applies to health and welfare plans, as well as retirement plans.

Facility Charge…means charges billed for by a CHI Facility on a universal billing "UB" form. The Facility Charge does not include any charges billed for separately by a Physician or other Provider.

Family Coverage… means coverage for you and your enrolled Dependents under this Plan. For purposes of this SPD Family Coverage will mean Employee/Child(ren), Employee/Spouse or Legally Domiciled Adult, or Employee/Spouse or Legally Domiciled Adult/Child(ren) coverage.

Financial Responsibility…means the degree of financial support sufficient to Claim and eligible Dependent as an exemption of the Eligible Person's federal income tax return.

Formulary…means a listing of preferred Brand-Named Drugs as determined by a committee or Pharmacists and Physicians based on safety, clinical efficacy, and cost of therapy.

Generic Drug…means drug products manufactured and distributed after the patent of the innovator brand-name drug has expired. The Generic Drug must have the same active ingredient, strength, and dosage form as its brand-name counterpart.

Group Coverage…means a plan whose members share a common relationship, such as employment or membership.

HDHP/HSA Covered Preventive Drugs...means certain approved drugs that will not be subject to the deductible on the Integrated HDHP/HSA. The drugs will, however, still have the appropriate coinsurance for the tier of the specific drug. These drugs can be found on the CVS/Caremark HDHP Plan Preventive Drug List. The list is located on the "Pharmacy Plan" page under the Benefit tab on the *well-being* pages found on InsideCHI at **http://home.catholichealth.net/wellbeing**. You can also check the Formulary Drug List for other medications that are covered on the plan. The cost of these drugs will apply to your deductible, and then coinsurance applies. See Pharmacy Coverage of Benefits for additional information.

Health Savings Account (HSA) …means an account funded by you and possibly your employer that can be used to cover the cost of covered services, including prescription drugs, up to the IRS annual limit or the accrued amount in your account.

HIPAA…means the Health Insurance Portability and accountability Act of 1996.

Home Health Care Program…means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of a registered professional nurse, the services of Physical Therapists, Hospital laboratories, and necessary medical supplies. It does not include Custodial Care Service.

Home Infusion Therapy Provider…means a duly licensed home infusion therapy Provider.

Hospice…means a duly licensed autonomous, centrally administered, nurse-coordinated program providing home, Outpatient, and Inpatient care for a covered Participant who is Terminally Ill and members of the Participant's family. At a Hospice, a team of healthcare Providers assists in providing Palliative Care and support to meet the special needs arising during the final stages of Illness, and during dying and bereavement. This team of Providers includes a doctor and nurse, and may also include a social worker, a clergy member or counselor and volunteers.

Hospice Care Program Provider…means an organization duly licensed to provide Hospice Care Program Services.

Hospice Care Program Service…means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of Hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special Hospice care unit.

Hospital…means a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by Registered Nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged, or similar institutions.

The term Hospital does not include a specialty institution or residential facility, or a U.S. Government Hospital or any other Hospital operated by a governmental unit, unless a charge is made by the Hospital that the patient is legally required to pay without regard to insurance coverage.

Infertility…means the inability to conceive a Child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Illness…means physical sickness or disease, pregnancy, or congenital anomaly.

Illness Affecting Mental Health…means those Illnesses, classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

Independent Clinical Laboratory…means a duly licensed facility where human materials or specimens are examined for the purpose of diagnosis, prevention, or treatment of a Condition.

Individual Coverage…means coverage under the health care plan for yourself.

Injury…means a bodily injury that is not related to any Illness.

In-Network Provider…means a Professional Provider which has a written agreement with the Claims Administrator to provide services to Participants.

Inpatient…means that you are a registered bed patient and are treated as such in a health care facility.

Intensive Care Unit…means a specialized area in a Hospital where an acutely ill patient receives intensive care or treatment. Included in the Hospital's charge for an Intensive Care Unit are the services of specially trained professional staff and nurses, supplies, and the use of any and all equipment and the patient's board. A coronary care unit is also considered an Intensive Care Unit.

Investigational…means procedures, drugs, devices, services and/or supplies which

- Are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency, effectiveness, and/or
- Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and
- Specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

Law Enforcement Official…means an officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, who is empowered by law to:

- Investigate or conduct an official inquiry into a potential violation of law; or
- Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Legal Guardian or Guardianship…means an individual who was appointed as guardian, conservator, loco parentis or similar role for a Child by a court having appropriate jurisdiction over such Child.

Legally Domiciled Adult means an individual over 18 who has, for at least six months, lived in the same principal residence of an employee and remains a member of that employee's household throughout the coverage period; and who either:

- Has an on-going, exclusive and committed relationship with the employee (not a casual roommate or tenant), shares basic living expenses and is financially interdependent with the employee, is neither legally married to anyone else nor legally related to the employee by blood in any way that would prohibit marriage.
- Is the employee's blood adult relative who meets the definition of his or her tax dependent as defined by Section 152 of the Internal Revenue Code during the coverage period and is not considered a Child as defined in this section of the Summary Plan Description.

Legend Drug…means a drug that is approved by the U.S. Food and Drug Administration (FDA) and is required by federal or state law to be dispensed to the public only on prescription of a licensed physician or other licensed provider. Legend drugs are also called prescription drugs.

Level of Coverage…means the medical Plan option selected by the Plan Participant.

Lifetime Maximum…means the maximum amount that this Plan will pay over the course of an Employee or Dependent's lifetime.

Maintenance Occupational, Physical and/or Speech Therapy…means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a Condition will occur.

Marriage and Family Therapist…means a duly licensed marriage and family therapist.

Massage Therapist…means a duly licensed massage therapist.

Massage Therapy…means the treatment for chronic pain by physical means by a Physician, registered professional Physical Therapist Chiropractor, or licensed Massage Therapist. Massage Therapy must be prescribed by a Physician and must be Medically Necessary.

Maternity Service…means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MBO…means a Market-Based Organization or facility of CHI.

Medical Care…means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an Illness or Accidental Injury.

Medically Necessary or Medical Necessity…means that a specific service provided to you is reasonably required, in the reasonable judgment of the Claims Administrator, for the treatment of management of a medical symptom or Condition and that the service provided is the most efficient and economical service which can safely be provided to you. When applied to Hospital Inpatient Services, Medically Necessary means that your medical symptoms or Condition require that the treatment be provided to you as an Inpatient and that treatment cannot safely be provided to you as an Outpatient. Further, Medically Necessary means that Inpatient Hospital care and treatment will not be covered when, in the reasonable judgment of the Claims Administrator, your medical symptoms and Condition no longer necessitate your continued stay in a Hospital. The fact that a Physician or other health care Provider may prescribe, order, recommend, or approve a service or supply does not of itself make such a service Medically Necessary.

Medicare…means the program established by Title XVIII of the Social Security Act (42 U.S.C.§ 395 et seq.).

Medicare Approved or Medicare Participating…means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare Program.

Medicare Secondary Payer or MSP…means those provisions of the Social Security Act set forth in 42 U.S.C.§ 395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain Employers may offer group health care coverage to Medicare-eligible Employees, their Spouses and, in some cases, Dependent Children.

Mental Health Condition…means an Illness Affecting Mental Health.

Mental Health Unit…means a unit established to perform preadmission review and length of stay review for Inpatient and/or Outpatient services for the treatment of Illness Affecting Mental Health and Substance Abuse.

Out-of-Network Provider…means a Hospital, Professional Provider, or facility which does not have a written agreement with the Claims Administrator to provide services to Participants. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services.

Occupational Therapist…means a duly licensed occupational therapist.

Occupational Therapy…means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Optometrist…means a duly licensed optometrist.

Organized Health Care Arrangement…means this Plan and each other health plan maintained by the Plan Sponsor, including the insurers that provide Benefits under any such plan.

Orthotic Provider…means a duly licensed orthotic Provider.

Out-of-Pocket Maximum…means the maximum amount you are required to pay in a Benefit Year for Eligible Medical and Prescription Charges for your Copayments, Coinsurance and Deductible. The Out-of-Pocket Maximum does not include penalties and charges that are ineligible for reimbursement.

Outpatient…means that you are receiving treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an Emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

Outpatient Facility…means a duly licensed facility other than a doctor's, physical therapist's or midwife's office that provides Outpatient services for treatment of an Illness or Accident, other than for Illness Affecting Mental Health or Substance Abuse.

Palliative Care…means reduction or abatement of pain and other troubling symptoms through services provided by members of the Hospice team of Providers.

Partial Hospitalization Treatment Program…means a Claims Administrator approved planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Illness Affecting Mental Health or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

Participant or **Plan Participant**…means a person covered under this Plan.

Permitted Disclosures…means any disclosure for purposes of payment, treatment, or health care operations of a plan or its Organized Health Care Arrangement as defined in HHS Reg. §164.501.

Permitted Uses…means any payment, treatment, or health care operation of the Plan or its Organized Health Care Arrangement as defined in HHS Reg. §164.501.

Pharmacist…means a duly licensed Pharmacist.

Pharmacy…means any licensed establishment in which the profession of Pharmacy is practiced.

Physical Therapist…means a duly licensed physical therapist.

Physical Therapy…means the treatment of a disease, injury, or Condition by physical means by a Physician or a registered profession physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician…means a Physician duly licensed to practice medicine in all of its branches.

Physician Assistant…means a duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist, or Podiatrist and billing under such Provider.

Plan…means the Medical Plan.

Plan Administrator or Plan Sponsor…means CHI.

Plan Administration Functions…means administration functions performed by Plan Sponsor personnel on behalf of a plan and excludes functions performed by the Plan Sponsor in connection with any other Benefit or Benefit plan of the Plan Sponsor.

Podiatrist…means a duly licensed podiatrist.

Post-Service Claim…means any claim for a Benefit under the Medical Plan that is not a Pre-Service Claim.

Prescription Drug…means a drug that bears the legend, "Caution, Federal Law prohibits dispensing without a prescription and meets the following criteria:

- Prescribed by a Provider who is legally authorized to prescribe;
- Dispensed by a recognized licensed retail Pharmacy, a contracting specialty Pharmacy, or through the mail-order drug program; and
- Is Medically Necessary for your Illness or Accidental Injury or is approved for Preventive or Wellness Care.

Covered drugs are limited to those taken orally, absorbed through the skin, and certain injected Prescription Drugs. Devices and implants are not considered to be Prescription Drugs.

Pre-Service Claim…means any Claim for a Benefit under the Medical Plan which is made in advance of obtaining the requested services or supplies.

Preventive Care or Preventive Care Services…means history and physical examinations, routine laboratory services, immunizations, routine history and gynecological exams, and well-child care, including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination, as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Primary Care Physician…means a general practitioner, family practitioner (family practice Physician), doctor of internal medicine (internist), pediatrician, doctor of obstetrics/gynecology, nurse practitioner, Registered Nurse, nurse-midwife, or Physician Assistant.

Prior Authorization…means the process of obtaining approval as to appropriateness of a medication before it is actually dispensed and utilized.

Privacy Officer…means the CHI Privacy Officer.

Private Duty Nursing Service…means Skilled Nursing Service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.), or a licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

Prosthetic Provider…means a duly licensed prosthetic Provider.

Protected Health Information…means information including demographic information collected from an individual, that is created or received by a plan and that is transmitted or maintained in any medium (including verbally) that

- Relates to the past, present, or future physical or mental health Condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- That identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information shall not include information that is de-identified in accordance with HHS Reg. §164.514(a). Protected Health Information also includes genetic information. Genetic information is information about an individual's family members, and the manifestation of a disease or disorder in the individual's family members. Family members include dependents and any other individual who is a first-, second-, third-, or fourth-degree relative
of the individual or the individual's Dependents.

Provider or Professional Provider…means a duly licensed provider designated by the Medical Plan to render Covered Services or Supplies to you as a Provider. For the services of these Providers to be covered, the service must meet the definition of Covered Services or Supplies, and the Provider must be providing the services or supplies within the scope of his or her license or certification.

Provider does not include athletic trainers; boarding houses; camps or schools; convalescent facilities, institutions for chronic care, personal care, residential or domiciliary care, or homes for the aged; dental assistants and dental hygienists; education or training programs; halfway houses; health resorts; health spas; hypnotists; homeopathic medical Providers, hotels, motels and other lodging; priests, and other religious affiliates; naturopaths; opticians; orthodontists; residential treatment centers; residents, interns, or other Employees of Hospitals or Skilled Nursing Facilities who bill for their services and are not listed as Covered Providers; rest homes; sanitariums; and other non-traditional medical Providers; transportation other than by Ambulance; and any facilities or Providers not specifically mentioned within this SPD that are not specifically designated by CHI to be eligible providers.

Psychologist…means a Registered Clinical Psychologist.

Prudent Layperson…means a person who possesses an average knowledge of health and medicine.

Qualified Status Change…means a life event such as:

- Marriage;
- Divorce, legal separation or annulment;
- Birth of a Child, adoption, placement for adoption, or Legal Guardianship;
- Change of a Child's eligibility status due to reaching the maximum age;
- Loss of Legal Guardianship;
- Death of a Child or Spouse;
- Changes in your work status that affect eligibility for Benefits;
- Changes in a Spouses work status affecting eligibility for Benefits;
- Gaining or losing eligibility for another plan such as expiration of COBRA coverage from another Employer's plan, gaining or losing eligibility for Medicare or Medicaid;
- Gaining or losing eligibility for the Medicaid or state Children's Health Insurance Program (CHIP); or

- Qualified Medical Child Support Order requiring you or your Spouse to provide health coverage for a Dependent.

Since this Plan is funded in part by pre-tax Employee contributions, it is governed by IRS regulations that indicate that a Participant may only change his or her Benefit Plan elections during Annual Enrollment unless there is a Qualified Status Change, and that the change elected must be consistent with the Qualified Status Change. All changes must be made within 31 days of the Qualified Status Change except changes in elections resulting from birth, adoption, gaining legal custody of a dependent child, or gaining or losing eligibility for Medicaid or state CHIP must be made within 60 days.

Qualified Exigency…means, as defined by the Department of Labor for purposes of the Family and Medical Leave Act, an Emergency arising out of one of the following categories:

- Short-notice deployment;
- Military events and related activities;
- Childcare and school activities;
- Financial and legal arrangements;
- Counseling;
- Rest and Recuperation;
- Post-deployment activities; and
- Additional activities not encompassed in the other categories but agreed to by the Employer and Employee.

Qualified Medical Child Support Order or QMCSO…means a medical Child support order, qualifying under ERISA and approved by the Plan Administrator, that provides for health care coverage and allocation of responsibility for the payment of costs for health care coverage for a natural or adopted Child of an Employee or Spouse.

Registered Dietitian…means a duly licensed registered dietitian.

Registered Nurse (RN) or Licensed Practical Nurse (LPN)…means a person duly licensed to practice nursing.

Registered Surgical Assistant…means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified, or Registered Nurse first assistant.

Related Professional Services…means services that are provided at the same time as the office visit (e.g., lab work done while in the doctor's office).

Renal Dialysis Treatment…means one unit of service, including the equipment, supplies, and administrative services which are customarily considered a necessary to perform the dialysis process.

Residential Treatment Facilities…means a duly licensed facility that treats an intermediate level of substance abuse on both an inpatient and outpatient basis. It provides a detailed regimen that includes full-time residence and full-time participation by the patient within a residential treatment facility which provides room and board, evaluation and diagnosis, counseling, referral and orientation to specialized community resources.

Skilled Nursing Facility…means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Service…means those services provided by a Registered Nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Specialist…means any Physician other than a Primary Care Physician who is classified as a Specialist by the American Boards of Medical Specialties; or who is designated by the Plan as a Specialist Physician.

Specialty Drug…means drugs that are typically used for treating or managing chronic Illnesses. These drugs often require special handling (e.g., refrigeration) and administration. Some Specialty Drugs may be taken orally, but others may require administration by injection, infusion, or inhalation. Specialty Drugs may not be available from a retail Pharmacy.

Speech Therapist…means a duly licensed Speech Therapist.

Speech Therapy…means the treatment for the correction of a speech impairment resulting from disease trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

Spouse…means a person who is legally married under the laws of the state where the marriage was celebrated to an employee who is participating in the health care benefits offered by CHI, regardless of where that couple currently resides.

Step Therapy or Step Therapy Program…means the program which requires you to first try one or more specified drugs to treat a particular Condition before the Plan will cover another (usually more expensive) drug that your Physician may have prescribed.

Substance Abuse…means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers, and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

Substance Abuse Rehabilitation Treatment…means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or Psychologist, court-ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation, or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Abuse Treatment Facility…means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses, or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Summary Health Information…means information that summarizes the Claims history, Claims expense or types of Claims experience by an individual for whom Benefits are or were provided under the Plan, provided that individual identifying information has been deleted.

Summary Plan Description or SPD…means this booklet which describes the features of this Benefit Plan.

Surgery…means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claims Administrator.

Suspected Breach…means the suspected unauthorized acquisition, access, use, or disclosure of Unsecured PHI.

Temporomandibular Joint Dysfunction (TMJ) and Related Disorders…means jaw joint Conditions including temporomandibular joint disorders and craniomandibular disorders, and all other Conditions of the joint linking the jaw bone and skull and the complex muscles, nerves, and other tissues relating to that joint.

Terminally Ill…means a person has a life expectancy of six months or less because of a chronic, progressive Illness that is incurable according to the person's doctor.

Unsecured PHI…means Personal Health Information (PHI) that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of one of the following technologies or methodologies:

- Encryption: Electronic PHI has been encrypted by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. (See encryption processes identified by HHS as having been tested by the National Institute of Standards and Technology (NIST) and judged to meet this standard.)
- Destruction: The media on which the PHI is stored or recorded has been destroyed in one of the following ways:
  - Paper, film, or other hard copy media have been destroyed such that PHI cannot be read or otherwise cannot be reconstructed.
  - Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization, such that the PHI cannot be retrieved.
- Any other technology or methodology specified by the Secretary of Health and Human Services for this purpose.

Urgent Care Facility…means a duly licensed Urgent Care Facility.

Urgent Pre-Service Claim or Appeal…means a review request that is expedited due to life changing or life-threatening circumstances for pre-service approval. The review takes 72 hours. You may be eligible for an expedited external review if you have a medical condition in which the normal timeframe for a standard external review or an expedited internal appeal could:

- Seriously jeopardize your life or health; or
- Your request involves an admission or continued stay, or health care service for which you received emergency services but have not yet been released.

You might also qualify for an expedited appeal if your request involves an experimental or investigation determination and your health care provider certifies in writing that the service/treatment would be significantly less effective if not promptly initiated.

Workforce Member…means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for an entity, is under the direct control of such entity, whether or not they are paid by such entity.

Eligibility Addendum

Initial eligibility requirements and effective date of coverage for employees vary by Market-Based Organization (MBO). All other eligibility provisions are determined by the Plan Administrator and are consistent across all MBOs and national offices. All MBOs have a Benefit Year beginning on January 1st and ending on December 31st.

Unless otherwise indicated, **Benefits will begin on the first of the month following your waiting period**. Hours listed are per pay period and are the regularly scheduled hours as reflected in the payroll system as the full-time equivalent or FTE. Where an employee holds more than one position with the Employer, the regularly scheduled hours will be added together for purposes of establishing the FTE for the purpose of benefits eligibility. An Employee's FTE will be evaluated and updated periodically throughout the year.

Market-based organization (MBO) or CHI Facility	City	State	Waiting Period	FT Hrs	PT Hrs
CHI National Offices	Various	All	30 days	64	40
Franciscan Health System	Tacoma	WA	30 days	32	n/a
Franciscan Medical Group	Tacoma	WA	30 days	64	40

3900 Olympic Boulevard
Suite 400
Erlanger, Kentucky 41018
www.catholichealthinitiatives.org

Effective January 1, 2019

APPENDIX B

BlueCross BlueShield of Illinois

MESSAGE CENTER - Inbox

« Back to Inbox

Inbox: Message Detail

Reply » Delete

From:	Customer Service	Group #:	C20051
Date:	05/10/2017 02:01 PM	Subscriber #:	[redacted]8820
To:	PATRICIA PRITCHARD	Reference #:	1-9652689555

Re: Dental

05/10/2017 14:01:48 - HCSC Response:
Hi Patricia,

You would need to get a copy of your actual benefit booklet for your plan from your human resources department to view the exclusions listed.

If you have any further questions or concerns, please contact our customer service department at the toll-free number on the back of your Blue Cross Blue Shield identification card or via the Message Center on Blue Access.

Megan D.

-- PATRICIA PRITCHARD - 05/09/2017 17:38:16 – Member Question:
Also, can you please provide me with the citation as to where the exclusion information exists in my plan.

Thank you,
Pattie

05/05/2017 10:41:11 - HCSC Response:
Hi Pattie,

When we say "the plan", we are reviewing to BCBS. You would need to file the appeal with us directly and we would review your case.

We apologize for any confusion.

If you have any further questions or concerns, please contact our customer service department at the toll-free number on the back of your Blue Cross Blue Shield identification card or via the Message Center on Blue Access.

Sincerely,
Marcus B.

-- PATRICIA PRITCHARD - 05/04/2017 15:50:05 -- Member Question:
Emily,
Thanks for your reply. I hope you meant this for me, since I'm not Elaine.

Below you state that the plan should notify me of the reasons for this determination. By that, do you mean Catholic Health Initiatives? Do you mean that I have to appeal this decision to them? I was told by CHI that I had to appeal it first to BCBS and then it would get routed back to CHI. Is this not the case? I'm trying to figure out who I need to appeal first to.

Thank you,
Pattie Pritchard

05/04/2017 11:58:38 - HCSC Response:
Hello Elaine,

We are sorry for the confusion that has occurred. Procedure codes 11981 and J9225 were originally approved in error. Under your benefit contract with Catholic Health Initiatives, transgender services are not covered. Since services for transgender related services are not a benefit of your contract then our Medical Review Unit will not review services for medical necessity. Below I have provided your appeal rights.

If payment of your claim has been denied in part of in full by your health care plan the plan shall notify you of:

The specific reason for adverse determination.
The Plan provision on which the determination is based.
A description of any additional information necessary for the Claimant to perfect the claim and an explanation why such information is necessary.
A description of the Plan's review procedures and applicable time limits, including a statement of the Claimant's right to bring a civil action under 502(a) of ERISA, if applicable, following an adverse determination of review.

The following conditions apply in the case of an adverse benefit determination by a group health Plan or a Plan providing disability benefits:
If an internal rule, guideline, protocol or other criterion was used in making the determination, the notification must state that the criterion was relied on in making the determination and that a copy will be provided free of charge upon request.

If based on medical necessity, experimental treatment or similar exclusion, either an explanation of such exclusion applying the terms of the Plan to the Claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request.

If you are not satisfied with the determination, please contact the Blue Cross and Blue Shield of Illinois (BCBSIL) Claim Review Section, P.O. Box 2401, Chicago, Illinois 60690. If, after investigation, BCBSIL determines that the claim (or portion of a claim) was correctly denied, you may appeal the denial as detailed below.

Under federal law, you are entitled to a full and fair review of the denied claim. Appeals must be made in writing within 180 days from the date you receive notice that your claim has been denied. You may submit written comments, documents, records and other information related to the claim for benefits with your appeal. You should also include any clinical documentation from your physician that would substantiate coverage of the denied claim.

You will receive a written decision within 60 days of receipt of your appeal request.

Upon request and free of charge, you will be provided reasonable access to and copies of all documents, records and other information relevant to your claim, including:
Information relied upon in making the benefit determination
Information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination
Descriptions of the administrative processes and safeguards used in making the benefit determination
Records of any independent reviews conducted by the Plan
Medical judgments, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate
Expert advice and consultation obtained by the Plan in connection with your denied claim, whether or not the advice was relied upon in making the benefit determination

For insured products, Rule 9.19 of the Rules and Regulations of the Illinois Department of Insurance requires that our company advise you that if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 100 W. Randolph Street, Suite 15-100, Chicago, Illinois 60601-1115, and in Springfield at 320 W. Washington Street, Springfield, Illinois 62767-0001.

If you have any further questions or concerns, please contact our customer service department at the toll-free number on the back of your Blue Cross Blue Shield identification card or via the Message Center on Blue Access.

Thank you,
Emily D.

-- PATRICIA PRITCHARD - 05/03/2017 14:29:47 -- Member Question:
Hello,
I have received 2 letters from BCBS stating that transgender care services will no longer be covered benefits for my son. Can you tell me why this is? Back in October I received an authorization stating it was covered and now I get a letter saying the authorization was simply a mistake.

Can I get a reason for denial of benefit?

Thank you,
Pattie Pritchard

02/28/2017 10:17:35 - HCSC Response:
Pattie,

Please be aware customer advocate, Portia N. is still working your inquiry on reference number 1-9257541100. I have reached out to Portia and advised that you are seeking an update to your original inquiry on the reference number. Portia will contact you once her research is complete in regard to claim 632055195H90H.

If we can be of further assistance, please let us know!

Thanks,
Jesse P.

-- PATRICIA PRITCHARD - 02/27/2017 12:45:03 -- Member Question:
Hello,
I actually spoke with 3 people on the 25th but never once did I actually get a specific reason for denial. No one has told me why this claim was denied. What I kept hearing was "hmmm... I see the authorization so I'm not sure why this was denied, someone will look into this".

Can someone please send me a denial in writing with specific information on the reason for denial?

Thank you,
Pattie Pritchard

02/25/2017 11:08:00 - HCSC Response:
Hi Patricia,

I have reviewed our files and noticed that you have spoken with a customer service representative since e-mailing our site regarding the denial of claim 632055195H90H for services rendered to C[redacted] on 11/08/16. I do show that this issue is being reviewed under your phone call.

Please contact us at the toll free number on the back of your identification card or via the message center if we can be of further assistance.

-- PATRICIA PRITCHARD - 02/24/2017 11:37:03 -- Member Question:
Hello,
I'm writing in response to claim number 020163205195H90H. I just spoke with a customer service person who says the claim was denied by our insurance. I have written authorization for services sent by you back in October, so I'm not sure why it's being denied. It is against the law to deny coverage for transgender individuals needing transition related care.

Pattie Pritchard

APPENDIX C

71112310648

BlueCross BlueShield of Illinois

April 21, 2017

Group Number: C20051
Identification Number: [redacted]8820
Patient Name: C[redacted] P[redacted]

Patricia Y Pritchard
[redacted]
Bremerton, WA 98310

Dear Member:

Blue Cross and Blue Shield of Illinois identified that treatment for transgender services were allowed incorrectly under the medical plan. Due to a multitude of errors which included verbal benefits, medical review and adjustment of claims by BCBS of Illinois, services on 09/27/16 and 11/08/16 will be allowed as a misquote of benefits and the member will be held harmless of our error.

For any future transgender services, benefits will not be covered under the medical plan. Please accept our sincerest apologies for any confusion that we may have caused. A follow up call will also be provided to ensure understanding.

If you have any questions in the interim, or need assistance please feel free to contact customer service at (866)776-4244, between the hours of 8:00 am and 6 pm, CST, Monday through Friday.

Sincerely,

Blue Cross Blue Shield of Illinois
CHI Service Center - 32822

BlueCross BlueShield
of Illinois

April 2017

Group Number: C20051
Identification Number: [redacted]8820
Patient Name: C[redacted] P[redacted]

Patricia Pritchard
[redacted]
Bremerton, WA 98310

Dear Patricia:

Blue Cross and Blue Shield of Illinois (BCBSIL) strives to provide excellent customer service.

Transgender services are not covered under the terms of your group health plan through Catholic Health Initiatives (CHI). We understand, however, that claims for transgender services dated September 27, 2016, and November 8, 2016, have been paid. We have determined you received inaccurate information that led you to believe these services would be covered.

You will not be responsible for any amounts previously paid with regard to the claims from September and November (except for the deductible and coinsurance amounts). Although those claims are not payable under the Catholic Health Initiatives group health plan, BCBSIL will pay the amounts directly. Therefore, all payments related to those claims will be covered by BCBSIL and not by the Catholic Health Initiatives group health plan. However, please be aware that any future claims for transgender services will not be covered as stated in the plan, and nothing in this letter modifies or waives any provision of the group health plan. We apologize for any confusion this may have caused. We will also follow up with a call to help ensure you understand the terms of the health plan.

If you have any questions or need help, please call Customer Service at **866-776-4244** weekdays between 8 a.m. and 6 p.m. CT.

Sincerely,

Blue Cross and Blue Shield of Illinois
CHI Service Center - 32822

APPENDIX D

Blue Cross and Blue Shield of Illinois
Claim Review Section
P.O Box 2401
Chicago, Illinois 60690

May 25, 2017

Re: BCBS Integrated Health Plan/CHI/FH
Group Number C20051
Identification Number [redacted]8820
Patient Name: C[redacted] P[redacted]

To Whom It May Concern:

Please accept this letter as my appeal to Blue Cross Blue Shield of Illinois for denial of coverage for transgender services for my son; services rendered and future coverage needed. This is in response to two "Notice of Action" letters I received in April 2017. One letter states: "Transgender services are not covered under the terms of your group health plan through Catholic Health Initiatives (CHI)". This is in direct conflict with a predetermination letter from Blue Cross Blue Shield of Illinois(BCBSIL), and inconsistent with multiple conversations/correspondences with employees of BCBSIL and CHI. It is also incongruous with the nondiscrimination policies of HMC/CHI/Franciscan Health(FH) and current practices by CHI endocrinologists who serve transgender patients.

A major hurdle in rectifying this situation is information provided by BCBSIL, CHI, FH, Harrison Medical Center (HMC), in addition to The Seattle Polyclinic is contradictory. Each entity (ies) has pointed the finger at the other organization(s) obfuscating responsibility of what we believe is discrimination because we were not provided adequate information about our benefits and our coverage was rescinded without meeting basic explanation requirements for denial of coverage as outlined from BCBSIL. At last review, we were instructed to appeal to BCBSIL our denial of coverage by Tyla Jones-Jackson of CHI Human Resources/Payroll Connection Support Center on May 1, 2017.

Following is a review of events, sampling records collected for consideration in this matter. I have also included the Non-Discrimination policy for HMC/CHI/FH, The Non-Discrimination Policy for BCBSIL, The Health Care Services Corporation Non-Discrimination Policy, and some supporting findings from the Human Rights Campaign, www.transgenderlawcenter.org, guidance from the Washington State Insurance Commission, and enclosed a letter from Dr. Kevin Hatfield (our son's specialty care provider for this issue). We are hoping to resolve this matter and better understand non-discrimination statements from these organizations serving the community and its incompatibility with discriminatory practices towards employees via health care benefits. We deserve to know, along with the local community, how Harrison Medical Center (a secular organization according to tax filing status) and its associated organizations are allowed to discriminate.

Here is a brief review of events:

1. September 24, 2016-Our son, C[redacted] P[redacted] had a new patient examination with Dr. Kevin Hatfield, a Family Practice Provider at the Seattle Polyclinic. He diagnosed our son with Gender Dysphoria, ran blood tests and obtained an x-ray. After receiving test results, our son was prescribed a puberty blocker- Vantas implant.
2. September 26, 2016- I contacted BCBSIL Message Center and asked- "I'm trying to locate the book that goes into detail about all of the benefits we have under our plan. Where can I find that?"
3. September 27, 2016- Heather T. of BCBSIL responded with- "The benefit booklets are issued by your employer. You will need to contact your employer to request the booklets as these are not housed with Blue Cross Blue Shield."
4. September 28, 2016- 9:55 a.m. CHI HR Reference #20368680 I contacted a Monique Lee who directed me to a summary plan for viewing[this is not a comprehensive plan].
5. September 28, 2016-10:42 a.m. CHI HR Reference #20368772- I contacted an Amber Brooks who again only said a summary plan was available and I was directed to BCBSIL for further details. At this point we are being told by BCBSIL to get necessary information from CHI, and CHI is instructing me to BCBSIL for comprehensive information.
6. October 14, 2016- We received a letter of predetermination from Clarisse P.-U346391 of BCBSIL stating: "Based on the documentation submitted, J9225 for Vantas [sic] implant is covered under the member's plan." We were relieved to discover the people with the greatest access to benefit coverage information [since we were not provided comprehensive information] had determined initial transgender services were covered for our son because of his diagnosed Gender Dysphoria.
7. November 11, 2016- C[redacted] returned to The Seattle Polyclinic and received the Vantas implant because BCBSIL had approved the services.
8. Since C[redacted] received the Vantas implant we have received conflicting information from BCBSIL and the Seattle Polyclinic regarding the status of these 2 dates of service, whether they are covered or not covered under my plan, and whether the billing codes were properly provided by the Seattle Polyclinic.
9. February 24, 2017- BCBSIL Reference #1-9247994104-I spoke with an Ira who indicated claim was finalized and not covered under our plan so coverage of implant and procedure was supposedly was denied.
10. February 24, 2017- BCBSIL Reference #1-9250986758-I spoke with a Portia who clarified the claims for coverage at that time were being denied only because the codes were incorrect, not because services were not covered. The implant had been approved but not the surgery because of an incorrect code. Portia expressed this was "weird" because "one goes with the other" and it doesn't make sense for one to be approved without the other. Portia said they would fix it and cover it once the billing codes were corrected for the surgical portion.
11. March 7, 2017- I received a Claim Detail- Claim number 0201632055195H90H stating BCBSIL plan would cover the implant and surgery. We further received a billing statement from the Seattle Polyclinic on April 18, 2017 indicating BCBSIL had already paid for part of the procedure and implant according to our benefits coverage. Payments made indicate to me services were covered and vetted properly and were in alignment with preceding correspondences.

12. March 7, 2017- I spoke with Amanda Bailey at CHI HR/Payroll Connection and inquired again about receiving a current Medical Summary Plan Description (the comprehensive plan) because I wanted that information to lessen confusion in the future. I could only find the 2016 plan but not the current 2017 edition. Amanda Bailey said "It looks like the only Medical SPD that is 140 pages is the 2016 one. We do not have a new one at this time." I asked if I could be contacted when the new one is available. She replied, "It doesn't look like anyone is aware of when this will be updated at the moment. You can always call BCBSIL[sic] and see if they have an updated summary on their end." This is after I was directed from BCBSIL to contact CHI HR for information, and now CHI was directing me to BCBSIL-again. How am I, as the consumer, able to understand coverage if neither entity are providing me with any up to date comprehensive information? Amanda emailed me a copy of the comprehensive Summary Plan Description the following day but as of May 25, 2017, it is still not available on CHI/HR Payroll Connection.
13. March 7, 2017 - BCBSIL Reference #9300608181- I spoke with a Tim who outlined the payments being made for services covered as another confirmation of coverage. We had not received any formal denial of claim for services covered at this point since payments were being made for correctly coded items/procedures.
14. April 21, 2017- We received a correspondence from BCBSIL stating: "treatment for transgender services were allowed incorrectly under the medical plan...For any future transgender services, benefits will not be covered under the medical plan." This clearly contradicts the letter of predetermination letter and has led to great confusion because it is contrary to previous correspondences.
15. May 3, 2017- BCBSIL Reference #1-9620863113- In the BCBSIL Message Center I asked in reference to our denial among other things- "What is the reason for this decision?"
16. May 4, 2017- BCBSIL Reference #1-9620633918- In a message from Emily D. an outline was provided about what BCBSIL needs to supply in response to a denial: "The specific reason for adverse determination. The Plan provision on which the determination is based", including other items. We had not received a specific reason at this point.
17. May 10, 2017- BCBSIL Reference #1-9652689555- In a message from Megan D. I was directed to CHI to find per the plan what services are excluded. Megan stated "You would need to get a copy of your actual benefit booklet for your plan from your human resources department to view the exclusions listed." Transition-related services are not listed in any book as exclusions.
18. May 10, 2017- CHI HR Payroll Connection Reference #20561880 I spoke with Tyla Jones-Jackson. I asked: "I'm trying to find out exactly what exclusions are included in our medical plan. I received a letter from BCBSIL in April saying my son's transgender care wouldn't be covered moving forward, that they made a mistake authorizing it back in November. I asked them to provide me the citation showing these exclusions because the[sic] 2016 and 2017 summary plan descriptions say nothing about transgender care." The response given was "I've researched it and it was determined that because it isn't a life threatening medical issue CHI will not be covering it this year". I responded with "Is there a specific citation that speaks to that?" Tyla responded "No, it's just something that CHI decided not to cover this year". I asked "They didn't cover it last year either, correct? My son started his treatment in 2016". She responded with "No, I couldn't find anything stating it was covered last year either". How does any of this seem

reasonable since so many people had vetted payment for services and corresponded affirming coverage? How does "No, it's just something that CHI decided not to cover this year" suffice as the specific reason for adverse determination or the plan provision on which the determination is based? If the Vantas implant is prescribed in situations that are not life threatening such as precocious puberty, how does this square in terms of being discriminatory if it is not provided for my son? And why has the information about coverage changed over time without any ability to reference this or any other justification of "life threatening" incidences?

19. May 11, 2017- I sent an email to a CHI endocrinologist inquiring whether they work with transgender patients to understand the relationship of serving transgender patients vs. supporting employees who are themselves transgender or have dependents who identify as transgender. This endocrinologist stated "I actually have quite a few transgender patients and enjoy working with this population."

I am disappointed and confused we were misled. I have faithfully served my community as a Social Worker with Harrison Medical Center for over 6 years. As a medical social worker I am required to follow hospital policies which state we do not discriminate against any patients (see below). The BCBSIL website also lists their non-discrimination policy (see below). How is it possible is these companies square the idea they support protections for gender identity for their patients/consumers but decline coverage for transgender services of people who serve their community as employees? Furthermore, how is it possible to not provide access to comprehensive information about coverage and/or exclusions for health benefits and rescind coverage and further deny coverage based on something that cannot be verified, justified, or properly cited?

The Non Discrimination Policy for Harrison Medical Center/CHI FH:

CHI FH does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of age, race, color, creed, national origin, ethnicity, religion, marital status, sex, sexual orientation, gender identity or expression, physical , mental or other disability, citizenship, medical condition, or any other basis prohibited by federal, state, or local law in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CHI FH directly or through a contractor or any other entity with which CHI FH arranges to carry out its programs and activities.

The Non Discrimination Policy for Blue Cross and Blue Shield of Illinois:

Non-Discrimination Notice: Health Care Coverage is Important for Everyone
We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

The Health Care Services Corporation (HCSC), a Mutual Legal Reserve Company and an Independent Licensee of the Blue Cross and Blue Shield Association also has a nondiscrimination policy:

Non-Discrimination Notice: Health Care Coverage is Important for Everyone
We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

The Health Care Services Corporation received a 100% Corporate Equality Index rating by the Human Rights Campaign in 2017. The Human Rights Campaign Foundation's 2017 Corporate Equality Index is the national benchmarking tool on corporate policies and practices pertinent to lesbian, gay, bisexual and transgender employees. Neither Harrison Medical Center, Catholic Health Initiatives, nor BCBS of Illinois were on the list but the licensee of BCBS of Illinois, the HCSC was on the list and received a top rating.

An increasing consensus has emerged among medical and mental health professionals affirming the need for adequate access to health coverage for transgender people. Organizations that have affirmed transgender health care as medically necessary and/or have affirmed that it is an act of discrimination to deny healthcare to transgender individuals include:

- The American Medical Association
- The National Association of Social Workers
- The American Psychological Association
- American Association of Clinical Endocrinologists
- American College of Obstetrician and Gynecologists
- The World Professional Association for Transgender Health
- American Psychiatric Association

From the Human Rights Campaign website (www.hrc.org):

> "Providing transgender-inclusive health coverage is not only the right thing to do. Inclusive health coverage also brings many invaluable benefits. The 2017 Williams Institute study asked employers who provide transition-related health coverage about the benefits they receive as a result. A majority of responding employers, 60%, stated that providing inclusive health coverage makes them more competitive and improves recruitment and retention. Furthermore, 60% reported that providing transgender-inclusive benefits demonstrates and effectively communicates their commitment to fairness and equality. Moreover, employers noted that offering inclusive healthcare benefits increases employee satisfaction and morale, helps attract a diverse workforce and puts them on the "leading edge."

In 2001, the City and County of San Francisco became the first US municipality to provide medically necessary transition-related care by removing transgender access exclusions for transgender workers. The city and county originally thought a small surcharge of $1.70 per member/per month would be necessary to cover the health care. Actual costs turned out to be far, far lower than anticipated however, and in 2006 the city dropped the surcharge altogether because the cost was so small as to be negligible.

"The financial cost of transition-related care, in short, is too low to matter," researcher Aaron Belkin wrote last year in a study in the New England Journal of Medicine. A survey was conducted in September 2013 by the Williams Institute on the Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans.
Key findings from the survey include:

- 85% of the 26 employers that provided information on costs of adding coverage to their existing health benefits plans reported no additional costs to add the coverage.

- Two-thirds of the 21 employers that provided information on actual costs from employee utilization of the coverage reported zero actual costs due to utilization.
- Based on the experiences of surveyed employers, we would predict that 1 out of 10,000 employees (among employers with 1,000 to 10,000 employees) and 1 out of 20,000 employees (among employers with 10,000 to 50,000 employees) will utilize transition-related health benefits annually when they are available.
- The type, number, and cost of services accessed by individuals will vary, yet as described above, the costs of these benefits, if any, are very low, as is the utilization of the benefit.

Employers further reported a variety of positive motivations for providing this coverage:

- 60% reported it would help them compete as an employer within their industry and would help with recruitment and retention.
- 60% stated it reflected their corporate values, including equality and fairness.
- 48% said they were motivated to improve employee satisfaction and morale.
- 44% noted it demonstrated their commitment to diversity and inclusion.

Regarding local competition as an employer, MultiCare Health System covers transition related care for their employees and dependents under the First Choice Health medical plan. Kaiser Permanente also covers their employees and dependents under their medical plan. Harrison Medical Center/CHI/FH needs to work with BCBSIL to offer their employees and their dependents the same level of coverage.

On May 19, 2017 NBC Bay Area published an article titled "New Guidelines for Transgender Kids Roll Back Age Limits for Hormone Therapy". A group of international physicians (endocrinologists, psychologists and psychiatrists) are working to rewrite the clinical guidelines for how and when to treat transgender children. The new revisions will no longer restrict hormone therapy to teenagers 16 and above. Studies from the Williams Institute at UCLA show that trans kids are "10 times more likely to commit suicide than non-trans kids". Research done by Dr. Kristina Olson, a research psychologist at the University of Washington has shown that "children who are allowed to transition socially are no more depressed and only marginally more anxious than other children". [http://www.nbcbayarea.com/investigations/Transgender-Kids-Eligible-for-Earlier-Medical-Intervention-Under-New-Guidelines-423082734.html].

Harrison Medical Center remains a secular hospital according to their tax filings. As a result, they are subject to ERISA laws and guidelines. ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

On June 25, 2014, the Washington State Office of Insurance Commissioner sent a memo to all insurance companies to clarify prohibitions in Washington State against discrimination in insurance coverage on the basis of gender identity or gender dysphoria. It states "broad exclusions of coverage on the basis of gender identity are prohibited under Washington state law. Additionally, denial of a medically necessary service on the basis of gender identity is prohibited under Washington state law".

Further, Washington State's Law against Discrimination, codified at Chapter 49.60 RCW, prohibits discrimination based upon sexual orientation, which includes "gender expression or identity," This prohibition applies in the "issuance, cancellation, or renewal of any contract of insurance, as well as

71532319510

amount of benefits payable, or any term, rate, condition, or type of coverage offered. RCW 48.30.300. While discrimination based on certain classifications is permissible "when bona fide statistical differences in risk or exposure have been substantiated," sexual orientation, including gender identity, is not one of those permitted classifications of discrimination".

Harrison Medical Center/CHI is not a covered entity under the ACA Section 1557, but they are still prohibited from discriminating on the basis of sex, gender identity or sexual orientation under Title VII of the Civil Rights Act and applicable Equal Employment Opportunity Commission (EEOC) regulations. Consequently, because Harrison Medical Center/CHI excludes coverage for gender transition, the Department of Health and Human Services Office of Civil Rights would refer the matter to the EEOC for investigation and enforcement.

In summary, we are asking for Blue Cross and Blue Shield of Illinois to work with Harrison Medical Center/Catholic Health Initiatives/Franciscan Health to correct the billing issues we have faced and provide inclusive medical coverage for staff and their dependents. We are asking for BCBS of Illinois to reverse their decision made in April 2017, to not discriminate, and allow transgender services to be covered under our medical plan. I would like an explanation of how this organization and its affiliation with Catholic Health Initiatives is applying its non-discrimination policy in our circumstances and their reasoning in terms of specific laws and/or a code of ethics if it exists in your organization. Additionally we would like to know how decisions made about coverage are fairly applied to consumers with adequate information, how it's possible to rescind coverage despite verification from numerous employees with the greatest access to benefit information, and how no specific justifiable reason or citation has been provided.

Sincerely,

Patricia Pritchard

Patricia Pritchard
Subscriber ID [redacted]8820

ENCLOSURE
Letter from Dr. Hatfield dated 5/11/17

APPENDIX E

BlueCross BlueShield of Illinois

October 19, 2017

Subscriber: Patricia Pritchard
Group/Sub. No.: [redacted]8820
Claim No.: Pre-Service Benefit Determination
Appeal ID No.: [redacted]8485
Appeal Type: [redacted]er

Patricia Pritchard
[redacted]
Bremerton WA 98310[redacted]

Phone: (866)776-4244
Fax: (918)551-2011
Email: SDOAppeals@bcbsil.com

Subject: We're reviewing your appeal

Dear Patricia Pritchard,

Your written appeal was received on June 02, 2017, for the below member and service(s). We're reviewing the appeal and will let you know our decision within 15 calendar days of the date received.

Our response may be delayed if more information is needed for the review. If that happens, we'll let you know what is needed.

This is your first appeal of one available to you.

Appeals Request	Coverage for Transgender services		
Member	C[redacted] P[redacted]	Provider	Kevin Hatfield, M.D.
Service Date(s)	Pre-Service Benefit Determination	Facility	The Polyclinic
Initial Decision	This service is not a benefit of the contract (provision is not covered).	Initial Decision Code	299
Initial Decision Date	April 21, 2017	Claim Amount	$0.00

If you'd like your appeal to be closed until more information can be added, please contact customer service. Keep in mind that appeals not received within 180 days of the denial letter (with time allowed for mail delivery) may not be reviewed. You have the option of making a statement about your case as well as giving us more data. If you plan to do this, please contact Customer Service at the number above.

To give us more information, send it to the address below. Please include your Claim Number and Appeal ID with the added items.

BlueCross BlueShield of Illinois

October 19, 2017

Subscriber:	Patricia Pritchard
Group/Sub. No.:	[redacted]8820
Claim No.:	Pre-Service Benefit Determination
Appeal ID No.:	[redacted]3485
Appeal Type:	Member

Patricia Pritchard
[redacted]
Bremerton WA 98310-[redacted]

Phone: (866)776-4244
Fax: (918)551-2011
Email: SDOAppeals@bcbsil.com

Blue Cross and Blue Shield of Illinois
PO Box 2401
Chicago, IL 60690
Fax: 918-551-2011

In certain cases, our decision letter and our acknowledgement letter may be sent at the same time. When this happens, you still have the chance to make a statement or present more information. Please contact us within 10 days of the date of our decision letter. We will then reopen your appeal and take your added items.

You may request a copy, free of charge, of the benefit term(s) or rule(s) we used to make our decision. If needed, you may also get a copy of all documents relevant to the appeal free of charge.

You may have options if we don't give you a timely response to this appeal or if you're not satisfied with the decision. You may be able to request an Independent External Review (IER) by an Independent Review Organization (IRO). This review is done at no cost to you. See the attached letter to learn about any IER rights you may have.

If you have questions or to request copies, please contact Customer Service at the number above.

Sincerely,

Kimberly ZH
U312876
Appeals Department

Cc: The Polyclinic
Kevin Hatfield MD

Attachment:
Triage IL Addenda- ASO Federal UGF

BlueCross BlueShield of Illinois

October 19, 2017

Subscriber:	Patricia Pritchard
Group/Sub. No.:	[redacted]8820
Claim No.:	Pre-Service Benefit Determination
Appeal ID No.:	[redacted]3485
Appeal Type:	Member

Patricia Pritchard
[redacted]
Bremerton WA 98310[redacted]

Phone:	(866)776-4244
Fax:	(918)551-2011
Email:	SDOAppeals@bcbsil.com

BlueCross BlueShield of Illinois

IMPORTANT INFORMATION (Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to:
Blue Cross and Blue Shield of Illinois
Claim Review Section
PO Box 2401
Chicago, IL 60690

To file an appeal or if you have questions, please call (866)776-4244 (TTY/TDD: 711), send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members℠ (BAM) at bcbsil.com

Authorized Representative

You can name a person to act for you (including an attorney) on your appeal or external review – known as an "authorized representative." To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form.

Standard Appeal

You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:

- A copy of the decision letter or Explanation of Benefits (EOB)
- The reference number or claim number (often found on the decision letter or EOB)

You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your initial appeal.

What happens next?	We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

Expedited (Urgent) Appeal

You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call us at (866)776-4244 (TTY/TDD: 711) or fax your

BlueCross BlueShield of Illinois

request to 918-551-2011. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling (866)776-4244.

What happens next?	If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request.

Your Right to a Standard External (Outside) Review

You may ask for an external review with an Independent Review Organization (IRO) if your appeal was denied based on any of the reasons below. You may also ask for external review if we failed to give you a timely decision as stated in the Standard Appeal section above, and your claim was denied for one of these reasons:

- A decision about the medical need for or the experimental status of a recommended treatment
- A condition was considered pre-existing
- Your health care coverage was rescinded (see your Benefit Booklet for details)

If your case qualifies for external review, an IRO will review your case (including any data you'd like to add), at no cost to you, and make a final decision. To ask for an external review, you'll need to complete the necessary form and submit it to BCBSIL. You may get a form by calling the number on your ID card. Unless your plan says otherwise, you have 4 months from the date you received the decision notice to file your external review request.

What happens next?	If you qualify for an External Review, an IRO will review your case and mail you its decision within 45 calendar days. That decision is final and binding on BCBSIL and you.

Expedited (Urgent) External Review

You can ask for this type of review if:

- failure to get treatment in the time needed to complete an Expedited Appeal or an External Review would seriously harm your life, health or ability to regain maximum function;
- the request is about an admission, availability of care, continued stay or health care service that you received with emergency services, before your discharge from a facility;
- the request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started; or,
- we failed to give you a decision within 72 hours of your request for an expedited appeal

The IRO that does the expedited external review will decide if the covered person needs to complete the expedited (urgent) appeal process before the Expedited (Urgent) External Review can be started. If you think your case may qualify for an Expedited External Review, call (866)776-4244.

What happens next?	If you qualify for this type of review, the IRO will give you a decision within 72 hours.

Notice about Provider Appeals

If you used an in-network provider, your provider may be able to file an appeal request for benefits you've

BlueCross BlueShield of Illinois

been denied. You and your provider may file appeals separately and at the same time. Deadlines for filing appeals or external review requests are not delayed by appeals made by your provider UNLESS you have chosen your provider to act for you as your authorized representative. Choosing your provider to act for you must be done in writing. If your provider is acting on your behalf, then the provider must meet the deadlines you would have to meet to file such requests.

Additional Rights

If you receive your benefits through an employer, you may also have the right to bring an action under Section 502(a) of a law called ERISA. To learn more, call the Employee Benefits Security Administration at 866-444-EBSA (3272).

Department of Insurance

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, wish to file a complaint or wish to take up your matter with the IDOI, you may use either address below.

IDOI
320 W Washington St
Springfield, IL 62767-0001
Review Request: 877-850-4740
Fax: 217-557-8495

IDOI, Office of Consumer Health Insurance
122 S Michigan Ave 19 Floor
Chicago, IL 60603
Complaints: 877-527-9431
Email: DOI.InfoDesk@illinois.gov

IDOI Web: https://mc.insurance.illinois.gov

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

Revision 11/21/2016

COMPLAINT - 181

BlueCross BlueShield of Illinois

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك او لدى شخص تساعده اسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen 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 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ní, éí doodago ła'da bíká anáníłwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóótí'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidgíí bee nił h odoonih. Ata'dahalne'igíí bich'į' hodíłnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

bcbsil.com

APPENDIX F

BlueCross BlueShield of Illinois

April 27, 2018

Patricia Pritchard
C/O C[redacted] P[redacted]
[redacted]
Bremerton, WA 9831[redacted]

Group/ID: [redacted]8820

Dear Ms. Pritchard:

I am writing in response to your inquiry received in our office on September 28, 2017.

Please see the attached letter sent to you on April 26, 2018.

Thank you for the opportunity to review your concerns. Should you have any further questions, we encourage you to contact our office directly at (866) 776-4244.

Sincerely,

Erica D. U312270
Executive Inquiry Specialist

Attachment

BlueCross BlueShield of Illinois

April 26, 2018

Patricia Pritchard
[redacted]
Bremerton WA 98310-[redacted]

Subscriber: Patricia Pritchard
Group/Sub. No.: [redacted]3820
Claim No.: 6278553554B0H and 632055195H90H
Appeal ID No.: 529758485
Appeal Type: Member

Phone: (866)776-4244
Fax: (918)551-2011
Email: SDOAppeals@bcbsil.com

Subject: Your appeal results

Dear Patricia Pritchard,

We received your request for an appeal on June 02, 2017 (the "Appeal"). The Appeal asserts that certain services received on September 27, 2016, and November 8, 2016 (the "Services") should have been covered under the Catholic Health Initiatives ERISA Welfare Benefit Plan (the "Plan"). The Appeal further requests future coverage under the Plan for services not yet incurred by your dependent child, C[redacted] P[redacted].

The appeal has been reviewed by an Appeals Specialist who had no involvement in the prior denial.

Appeal Decision	After careful review of the information we have, the appeal request has been **denied.**

Service(s)	Services related to Gender-reassignment		
Member	C[redacted] P[redacted]	Provider	Kevin Hatfield, M.D.
Service Date(s)	9/27/16, 11/8/16 and Pre-Service Benefit Determination	Facility	The Polyclinic
Initial Decision	This service is not a benefit of contract (provision is not covered).	Initial Decision Code	299
Initial Decision Date	April 21, 2017	Claim Amount	$0.00

This decision is based on:

Catholic Health Initiatives ("CHI") sponsors the Plan, which is self-funded (i.e., not insured by Blue Cross and Blue Shield of Illinois ("BCBSIL")). BCBSIL, on behalf of the Plan, provides administrative services for the Plan, including the processing of the health benefit claims. The Plan determines the eligibility, membership, benefit

BlueCross BlueShield of Illinois

April 26, 2018

Subscriber:	Patricia Pritchard
Group/Sub. No.:	[redacted]8820
Claim No.:	6278553554B0H and 632055195H90H
Appeal ID No.:	529758485
Appeal Type:	Member

Patricia Pritchard
[redacted]
Bremerton WA 98310-[redacted]

Phone:	(866)776-4244
Fax:	(918)551-2011
Email:	SDOAppeals@bcbsil.com

coverages, and benefit exclusions; BCBSIL processes the claims in accordance with the benefits established by the Plan Sponsor under the Plan.

Your claims file and request for appeal have been reviewed and it has been determined that the Services are not covered under the Plan. Notwithstanding the foregoing, the claims for the September 27, 2016 and November 8, 2016 Services have been processed as outlined in the letter dated April 21, 2017.

The Glossary of Terms on page 116 of the Summary Plan Description (SPD) that was provided to BCBSIL by the Plan Sponsor defines Covered Service or Covered Services and Supplies as "a service and/or supply specified in this SPD for which Benefits will be provided." The Plan's SPD states the following:

Details – What's Covered and Not Covered page 30 states:

"Benefits described in this section will be provided only when you receive services on or after your Coverage Date and the services must be Medically Necessary. All Covered Services and Supplies listed in this section are subject to the General Conditions of Coverage, Exclusions, and Limitations section of this Summary Plan Description (SPD). If a service or supply is not specifically listed, do not assume that it is a Covered Service. Benefits are typically not provided for services or supplies that are not specifically mentioned in this SPD."

The plan General Conditions of Coverage, Exclusions, and Limitations on page 65 states:

"The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services, supplies, devices, and drugs mentioned in this Summary Plan Description (SPD)."

General Exclusions, on pages 65 - 66 states:

"Even if a service, supply, device, or drug is listed as otherwise covered in The Details – What's Covered and Not Covered section of this SPD, it is not eligible for Benefits if any of the following general exclusions apply:

Services Not Mentioned

You are not covered for any service, supply, or device that is not specifically mentioned in this SPD."

Therefore the Services are excluded from coverage under the Plan.

BlueCross BlueShield of Illinois

April 26, 2018

Patricia Pritchard
[redacted]
Bremerton WA 98310-[redacted]

Subscriber:	Patricia Pritchard
Group/Sub. No.:	[redacted]3820
Claim No.:	6278553554B0H and 632055195H90H
Appeal ID No.:	529758485
Appeal Type:	Member
Phone:	(866)776-4244
Fax:	(918)551-2011
Email:	SDOAppeals@bcbsil.com

Please note that the Plan does not allow for appeals related to health care services that have not yet been rendered (unless a prior authorization is a prerequisite to being eligible for maximum benefits under the plan). Accordingly, your request related to future services cannot be considered at this time.

Based on your Plan, this is your final internal appeal.

You may request a copy, free of charge, of the benefit term(s) or rule(s) we used to make our decision. If needed, you may also get a copy of all documents relevant to the appeal free of charge. This includes any new or added evidence that we didn't have at the time of our first decision. If you'd like a description of the medical code(s), you may ask for that as well. For more information please see the Attachment.

If you have questions or to request copies of the documents described above, please contact Customer Service at the number above.

Sincerely,

Kimberly ZH
U312876
Appeals Department

Cc: The Polyclinic
Kevin Hatfield MD

Attachment:
Triage IL Addenda- ASO Federal UGF

BlueCross BlueShield of Illinois

IMPORTANT INFORMATION (Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to: Blue Cross and Blue Shield of Illinois
Claim Review Section
PO Box 2401
Chicago, IL 60690

To file an appeal or if you have questions, please call (866)776-4244 (TTY/TDD: 711), send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members℠ (BAM) at bcbsil.com

Authorized Representative

You can name a person to act for you (including an attorney) on your appeal or external review – known as an "authorized representative." To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form.

Standard Appeal

You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:

- A copy of the decision letter or Explanation of Benefits (EOB)
- The reference number or claim number (often found on the decision letter or EOB)

You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your initial appeal.

What happens next?	We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

Expedited (Urgent) Appeal

You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call us at (866)776-4244 (TTY/TDD: 711) or fax your

BlueCross BlueShield of Illinois

request to 918-551-2011. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling (866)776-4244.

What happens next?	If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request.

Your Right to a Standard External (Outside) Review

You may ask for an external review with an Independent Review Organization (IRO) if your appeal was denied based on any of the reasons below. You may also ask for external review if we failed to give you a timely decision as stated in the Standard Appeal section above, and your claim was denied for one of these reasons:

- A decision about the medical need for or the experimental status of a recommended treatment
- A condition was considered pre-existing
- Your health care coverage was rescinded (see your Benefit Booklet for details)

If your case qualifies for external review, an IRO will review your case (including any data you'd like to add), at no cost to you, and make a final decision. To ask for an external review, you'll need to complete the necessary form and submit it to BCBSIL. You may get a form by calling the number on your ID card. Unless your plan says otherwise, you have 4 months from the date you received the decision notice to file your external review request.

What happens next?	If you qualify for an External Review, an IRO will review your case and mail you its decision within 45 calendar days. That decision is final and binding on BCBSIL and you.

Expedited (Urgent) External Review

You can ask for this type of review if:

- failure to get treatment in the time needed to complete an Expedited Appeal or an External Review would seriously harm your life, health or ability to regain maximum function;
- the request is about an admission, availability of care, continued stay or health care service that you received with emergency services, before your discharge from a facility;
- the request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started; or,
- we failed to give you a decision within 72 hours of your request for an expedited appeal

The IRO that does the expedited external review will decide if the covered person needs to complete the expedited (urgent) appeal process before the Expedited (Urgent) External Review can be started. If you think your case may qualify for an Expedited External Review, call (866)776-4244.

What happens next?	If you qualify for this type of review, the IRO will give you a decision within 72 hours.

Notice about Provider Appeals

If you used an in-network provider, your provider may be able to file an appeal request for benefits you've

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been denied. You and your provider may file appeals separately and at the same time. Deadlines for filing appeals or external review requests are not delayed by appeals made by your provider UNLESS you have chosen your provider to act for you as your authorized representative. Choosing your provider to act for you must be done in writing. If your provider is acting on your behalf, then the provider must meet the deadlines you would have to meet to file such requests.

Additional Rights

If you receive your benefits through an employer, you may also have the right to bring an action under Section 502(a) of a law called ERISA. To learn more, call the Employee Benefits Security Administration at 866-444-EBSA (3272).

Department of Insurance

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, wish to file a complaint or wish to take up your matter with the IDOI, you may use either address below.

IDOI
320 W Washington St
Springfield, IL 62767-0001
Review Request: 877-850-4740
Fax: 217-557-8495

IDOI, Office of Consumer Health Insurance
122 S Michigan Ave 19 Floor
Chicago, IL 60603
Complaints: 877-527-9431
Email: DOI.InfoDesk@illinois.gov

IDOI Web: https://mc.insurance.illinois.gov

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

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You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone: 800-368-1019
200 Independence Avenue SW	TTY/TDD: 800-537-7697
Room 509F, HHH Building 1019	Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

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If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك او لدى شخص تساعده اسئلة، فلديك الحق في الحصول على المساعدة و المعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen 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 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago la'da bíká anánilwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bínà'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodiilnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

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Revision 11/21/2016

APPENDIX G

BlueCross BlueShield of Illinois

Medical Policies

Medical Policies - Surgery

Print

Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

Number: SUR717.001

Effective Date: 05-01-2019

Coverage:

CAREFULLY CHECK STATE REGULATIONS AND/OR THE MEMBER CONTRACT

Gender Assignment Surgery

Gender assignment surgery for patients with ambiguous genitalia diagnosed at birth or in infancy **is considered reconstructive surgery and may be considered medically necessary.**

Gender Reassignment Surgery

NOTE: State Legislation may apply. Carefully check for legislative mandates that may apply for each plan.

ILLINOIS Legislative Mandate: 50 Illinois. Administrative. Code 2603.35 provides that a group health insurance plan that is neither a grandfathered plan nor a plan offering excepted benefits shall not discriminate on the basis of an insured's or prospective insured's actual or perceived gender identity, or on the basis that the insured or prospective insured is a transgender person.

Pursuant to the above, Gender Reassignment Surgery would be a covered benefit for Illinois insured policies subject to the coverage criteria set forth below.

CAREFULLY REVIEW the member's benefit contract for gender reassignment surgery and related services provisions. If there is a discrepancy between this medical policy and the member's benefit contract, the contract will govern.

Gender reassignment surgery -- also known as transsexual surgery or sex reassignment surgery -- and related services **may be considered medically necessary when meeting the criteria for gender dysphoria listed below**.

Otherwise, gender reassignment surgery and related services **will be considered not medically necessary**.

Criteria for Coverage of Gender Reassignment Surgery and Related Services:

The individual being considered for surgery and related services must meet **ALL** the following criteria. The individual **must have**:

- Reached the age of majority; **AND**

- The capacity to make a fully informed decision and to consent for treatment; **AND (ALERT -** For Gender Reassignment Surgery and Related Services for Children and Adolescents within this coverage, **proceed down** through this coverage section to the area **following NOTE 4.)**

- Been diagnosed with persistent, well-documented gender dysphoria; **AND**

- The required referrals prior to any surgery or related service(s):

  o Prior to feminizing or masculinizing hormonal therapy, one required referral from the individual's qualified mental health professionals (see **NOTE 1** below) competent in the assessment and treatment of gender dysphoria; **and/or**

  o Prior to breast/chest surgery, e.g., mastectomy, chest reconstruction, or breast augmentation, one required referral from the individual's qualified mental health professionals (see **NOTE 1** below) competent in the assessment and treatment of gender dysphoria; **and/or**

  o Prior to any genital surgery, e.g., hysterectomy, salpingo-oophorectomy, orchiectomy, and/or other genital reconstructive procedures, two separate required independent referrals (or one signed by both referring providers) from the individual's qualified mental health professionals (see **NOTE 1** below) competent in the assessment, treatment of gender dysphoria, and addressing the identical/same surgery to be performed.

NOTE 1: Psychotherapy and Mental Health Services:

Psychotherapy is not required for gender reassignment services except when a mental health professional recommends psychotherapy based on initial assessment prior to gender reassignment surgery. The recommendation for psychotherapy must specify the goals of treatment along with estimates of the frequency and duration of therapy throughout the individual's experience living in one's affirmed gender. Review the criteria above under "Criteria for Coverage of Gender Reassignment Surgery and Related Services" for required surgical referral letters from qualified mental health professionals.

Pharmaceutical Gender Reassignment Services:

Continuous hormone replacement therapy **may be considered medically necessary** prior to gender reassignment of either male-to-female (MtF) or female-to-male (FtM) surgical services **OR** following gender reassignment MtF or FtM surgical services.

Continuous hormone replacement therapy may include the following services:

- Hormone injections by the medical provider, such as during an office visit; and/or

- Self-administered oral and injectables obtained from a pharmacy.

NOTE 2: It is not uncommon for an individual to receive continuous hormone replacement therapy for 12-months or more.

Pharmaceutical agents to treat hair loss or growth, sexual performance post-gender reassignment genital surgery (e.g., Viagra or Cialis), and/or cosmetic enhancements, including collagen and/or botulinum toxin injections, **are considered not medically necessary.**

Gender Reassignment Laboratory Services:

Laboratory testing to monitor continuous hormonal replacement therapy for treatment of gender dysphoria **may be considered medically necessary**.

Primary Sexual Characteristic Gender Reassignment Chest and/or Genital Surgeries:

Male-to-Female (MtF) surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:

- Breast modification, including but not limited to breast enlargement, breast augmentation, mastopexy, implant insertion, and silicone injections, and nipple or areola reconstruction;
- Clitoroplasty;
- Coloproctostomy;
- Colovaginoplasty;
- Labioplasty;
- Orchiectomy;
- Penectomy;
- Penile skin inversion;
- Repair of introitus;
- Vaginoplasty with construction of vagina with graft; and/or
- Vulvoplasty.

Female-to-Male (FtM) surgical procedures performed as part of gender reassignment services for an individual who has met the above criteria for gender dysphoria **may be considered medically necessary** and include the following:

- Hysterectomy;
- Metoidioplasty;
- Phalloplasty;
- Placement of an implantable erectile prostheses;

- Placement of testicular prostheses;
- Salpingo-oophorectomy;
- Scrotoplasty;
- Subcutaneous mastectomy, including nipple or areola reconstruction;
- Vaginectomy (colpectomy);
- Urethroplasty; and/or
- Urethromeatoplasty.

Secondary Sexual Characteristic (Masculinizing or Feminizing) Gender Reassignment Surgeries and Related Services:

Procedures or services to create and maintain gender specific characteristics (masculinization or feminization) as part of the overall desired gender reassignment services treatment plan **may be considered medically necessary for the treatment of gender dysphoria ONLY.** These procedures may include the following:

- Abdominoplasty;
- Blepharoplasty;
- Brow lift;
- Calf implants;
- Cheek implants;
- Chin or nose implants;
- External penile prosthesis (vacuum erection devices);
- Face lift (rhytidectomy);
- Facial bone reconstruction/sculpturing/reduction, includes jaw shortening;
- Forehead lift or contouring;
- Hair removal (may include donor skin sites) or hair transplantation (electrolysis or hairplasty);
- Laryngoplasty;
- Lip reduction or lip enhancement;
- Liposuction/lipofilling or body contouring or modeling of waist, buttocks, hips, and thighs reduction;
- Neck tightening;
- Pectoral implants;
- Reduction thyroid chondroplasty or trachea shaving (reduction of Adam's apple);
- Redundant/excessive skin removal;

- Rhinoplasty (nose correction);
- Skin resurfacing;
- Testicular expanders;
- Voice modification surgery; and/or
- Voice (speech) therapy or voice lessons.

NOTE 3: Preparatory or ancillary procedures (such as anesthesia, tissue harvesting for skin, fat, nerve or muscle grafting, etc.) and supplies or equipment (such as stents, prosthesis, implants, etc.) that are required for the procedures listed above are considered an integral part of the MtF or FtM transition process.

NOTE 4: Surgical repairs or revisions related to MtF or FtM procedures may be required, such as removal and replacement of prostheses.

Gender Reassignment Surgery and Related Services for Children and Adolescents:

The following services **may be considered medically necessary** for the treatment of gender dysphoria for children and adolescents:

- Hormone therapy (such as, puberty-suppressing hormones or masculinizing/feminizing hormones);
- Psychological services, including but not limited to psychotherapy, social therapy, and family counseling; and/or
- Chest surgery for FtM individuals.

NOTE 5: The 2012 World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) (6) state the following regarding adolescent individuals seeking irreversible interventions, such as genital surgery:

"Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with the gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention."

Gender Primary or Secondary Sexual Characteristic Revision Surgeries

When there is documented evidence of physical functional impairment, gender primary or secondary sexual characteristic revision procedures or services **are considered medically necessary**.

When there is **no** documented evidence of physical functional impairment, gender primary or secondary sexual characteristics revision services **are considered not medically necessary** (refer to appropriate procedure-specific policy).

Preventive Medicine Gender Reassignment Services:

Preventive medicine services **considered medically necessary in conjunction with gender reassignment services include**:

- Breast cancer screening for FtM individuals; or
- Cervical cancer screening for FtM individuals; or
- Prostate cancer screening for MtF individuals; or
- Contraception pharmaceuticals for FtM individuals at risk of pregnancy.

Gender Reassignment Reproductive Services:

Procurement, cryopreservation/freezing, storage/banking, and thawing of reproductive tissues, such as oocytes, ovaries, embryos, spermatozoa, and testicular tissue **may be considered medically necessary for individuals with gender dysphoria because** gender reassignment services, such as long-term cross-sex hormone therapy or surgical procedures, may render an individual infertile whether or not the individual has reproduced in the past.

Reversal of Gender Reassignment Surgical Procedures

For reversal of any of the prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics, the patient **must meet the same criteria for gender dysphoria** to have those reversal procedures **considered medically necessary**.

If the criteria for gender dysphoria is not met, then reversal of any prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics **is considered not medically necessary.**

Description:

Gender Assignment Surgery

Gender assignment surgery (GAS), also known as genitoplasty, is genital reconstruction of ambiguous genitalia in newborns or infants difficult to classify as a male or female. The extent of the ambiguity varies. In very rare instances, the physical appearance may be fully developed as the opposite of the genetic sex (e.g., a genetic male may have developed the appearance of a typical female). (1) To the lay person the determination of an infant's sex can easily be identified as male or female, by virtue of outward genital anatomy, secondary sexual characteristics and behavior within their relevant cultural context. Arriving at a satisfactory scientific definition is more difficult as gender reflects the outcome of complex interactions occurring from the time of conception and extending throughout pre- and postnatal life. (2)

Intersex anomalies associated with ambiguous genitalia may result from major chromosomal abnormalities or from specific gene mutations as in congenital adrenal hyperplasia. (2) Typically, the ambiguous genitalia in genetic females (babies with two X chromosomes) include an enlarged clitoris that has the appearance of a small penis. The urethral opening can be anywhere along, above, or below the surface of the clitoris. The labia may be fused, resembling a scrotum. The infant may be thought to be a male with undescended testicles. Sometimes a lump of tissue is felt within the fused labia, further making it look like a scrotum with testicles. (3, 4)

In a genetic male (babies with one X and one Y chromosome), the ambiguous genitalia typically include a small penis (less than 2-3 centimeters or 0.8-1.2 inches) that may appear to be an enlarged clitoris (the clitoris of a

newborn female is normally somewhat enlarged at birth). The urethral opening may be anywhere along, above, or below the penis; it can be placed as low as on the peritoneum, further making the infant appear to be female. There may be a small scrotum with any degree of separation, resembling labia. Undescended testicles commonly accompany ambiguous genitalia. (3, 4)

Disorders which include ambiguous genitalia, which are usually not life threatening, have serious and potentially lifelong consequences for the affected child and, depending on the underlying cause, are likely to entail surgery in childhood and in later life, for example endocrine replacement therapy in conjunction with steroid replacement for those with congenital adrenal hyperplasia. (1) Making a correct determination of gender is both important for treatment purposes, as well as the emotional well-being of the child. Some children born with ambiguous genitalia may have normal internal reproductive organs. However, others may experience health issues from an underlying cause of the disorder. A list of the most common causes is listed below:

• Pseudohermaphroditism, the genitalia are of one sex, but some physical characteristics of the other sex are present.

• True hermaphrodism, a very rare condition in which both ovarian and testicular tissue is present. The child may have parts of both male and female genitalia.

• Mixed gonadal dysgenesis, an intersex condition in which there appears some male structures (gonads, testis), as well as a uterus, vagina, and fallopian tubes.

• Congenital adrenal hyperplasia, a potentially life-threatening condition, has several forms, but the most common form causes the genetic female to appear male.

• Chromosomal abnormalities, including Klinefelter's syndrome (XXY) and Turner's syndrome (XO).

• Maternal ingestion of certain medications (including androgenic steroids) may cause a genetic female to look more male.

• Lack of production of specific hormones can cause the embryo to develop with a female body type regardless of genetic sex, such as the lack of testosterone cellular receptors. (1)

Regulatory Status

Gender assignment surgical procedures are surgical interventions and, as such, are not subject to regulation by the U.S. Food and Drug Administration (FDA).

Gender Reassignment Surgery

Gender dysphoria (formerly known as 'gender identity disorder') is a condition recognized by the Diagnostic and Statistical Manual (DSM) of Mental Disorders and commonly known as transsexualism. (5) The diagnostic criteria describe many individuals who experience dissonance between their sex at

birth and personal gender identity, which is not the same as having ambiguous genitalia. According to the American Academy of Pediatrics, based on population surveys completed in 2014 of 17 states, it suggested that the number of adults who identify as "gender non-conforming" or transgender is 0.6% (1.4 million). (7) On the basis of that data, it is estimated that 0.7% of youth, ages 13 to 17 years (~150,000) identify as transgender.

Gender reassignment surgery (GRS) is also known as sex reassignment surgery; genital reconstruction surgery; sex affirmation surgery; sex realignment surgery; intersex surgery, or sex-change operation. It is a term used for the culmination of a series of surgical procedures and treatments by which a person's physical appearance and the function(s) of existing sexual characteristics are altered or even irreversibly changed to that of the opposite sex. Gender reassignment generally consists of several treatment plans, which include the diagnostic phase (mostly supported through mental health professional interaction) followed by continuous hormonal therapy (through an endocrinologist). It includes living openly in a manner consistent with the affirmed gender or completed with the GRS itself. (5)

Other terms are used to describe these procedures. These include sex reconstruction surgery; gender confirmation surgery; feminizing genitoplasty or penectomy, orchidectomy and vaginoplasty for trans women, with masculinizing genitoplasty or phalloplasty for trans men. (Definitions of these procedures can be found later in this Description section.) These procedures and services are used to treat individuals diagnosed with gender dysphoria in transsexual or transgender people. (1, 2, 6)

Guidelines for GRS and related services have been developed by the World Professional Association for Transgender Health (WPATH) (1), formerly known as the Harry Benjamin International Gender Dysphoria Association. WPATH is an international, multispecialty, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. In May 2010, WPATH urged de-psychopathologization of gender nonconformity worldwide by stating, "The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative." WPATH clarified the related procedures and services when an individual is considering surgical transformation from male-to-female (MtF) or female-to-male (FtM), as well as how the treatment differs for gender dysphoria and transsexualism. (1)

WPATH Standards of Care (SOC)

The WPATH SOC document provides an overview of surgical procedures to treat patients with gender dysphoria, otherwise known as gender affirming surgeries. (6, 7)

"For the MtF (male-to-female) patient, surgical procedures may include the following:

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures."

"For the FtM (female-to-male) patient, surgical procedures may include to following:

1. Breast/chest surgery: subcutaneous mastectomy, creation of male chest;

2. Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicle or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures."

SOC criteria for surgical services were introduced as a guide to decision making for breast/chest and genital surgery. (6) However, the SOC does not include criteria for other surgical procedures, such as masculinizing or feminizing facial surgery. The SOC does not stipulate the number, sequence, and/or timing of surgical procedures because they will vary from patient to patient, according to an individual patient's clinical needs and expectations, in collaboration with mental health and surgical professionals. (6)

Terminology in Relationship to Gender Reassignment Surgery and Related Services

Health care terminology for transsexual, transgender, and gender nonconforming individuals is rapidly evolving; new terms are being introduced and definitions of existing terms are changing. This tends to create misunderstanding, debate, or disagreement about the language used in this field.

For the purposes of this policy document, we have defined terms that may be unfamiliar or that have specific meanings in the "SOC." Although others may adopt these definitions, WPATH has acknowledged that the terms they use may be defined differently in different cultures, communities, and contexts. (1)

• Affirmed gender is when an individual's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic. (7)

• Agender is an individual who does not identify as having a particular gender. (7)

• Bioidentical hormones are structurally identical to those found in the human body and generally derived from plant sources. The hormones used in bioidentical hormone therapy (BHT) need to be commercially processed to become bioidentical. (6)

• Bioidentical compounded hormone therapy (BCHT) are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for an individual according to a physician's specifications. (6)

• Cisgender or cissexual describes related types of gender identity perceptions, where the individuals' experiences of their own gender agree with the sex they were assigned at birth. Cisgender may be a complement to transgender. (6)

• Cross-sex hormone therapy, transgender hormone therapy or medical affirmation refers to a form of hormone replacement therapy in which sex hormones and other hormonal medications are administered for the purpose of more closely aligning with the individual's secondary sexual characteristics. (7)

• Disorders of sex development are the congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (1), preferring the terms intersex and intersexuality.

• Female-to-Male (FtM) describes individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role. (6)

• Feminizing hormone therapy for transgender women or transfeminine individuals consists of estrogens and antiandrogens/androgen inhibitor. (7)

• Gender diverse is an umbrella term to describe an ever-evolving array of labels that individuals may apply when their gender identity, expression, or even perception does not conform to the norms and stereotypes others expects of their assigned sex. (7)

• Gender dysphoria, formerly known as gender identity disorder, is characterized by strong persistent cross-gender identification or a discrepancy between with the continuous discomfort or distress about one's anatomic sex (person's sex assigned at birth) or, by a sense of inappropriateness in the gender role of that sex. (1, 2) This includes inappropriateness clinically causes impairment in social, occupational, or other important areas of functioning. (2)

• Gender identity is the intrinsic sense of knowing to which sex one belongs—that is the awareness that 'I am female" (a girl or woman), or "I am male" (a boy or a man). Gender identity is the private experience of gender role and gender role is the public expression of gender identity. Gender role can be defined as everything one says and does, including sexual arousal, to indicate to others or to oneself the degree to which one is male or female. Some individuals describe themselves not as gender-nonconforming, but as unambiguously cross-sexed or unique/transitional. Such individuals no longer consider themselves to be either male or female. An individual may never fully embrace the gender role they were assigned at birth or an individual may actualize their gender identity, role, and expression in a way that does not involve a change from one gender to another gender. (1, 6) Gender identity and sexual orientation (see below) are distinct but interrelated constructs. Therefore, being transgender does not imply a sexual orientation, and individuals who identify still identify as straight, gay, bisexual, etc., on the basis of their attractions. (7)

• Gender identity disorder is a psychiatric diagnosis defined previously in the DSM-IV (changed to "gender dysphoria" in the DSM-5). This diagnosis is no longer appropriate for use and may lead to stigma, but the term may be found in older research. (7)

• Gender non-conforming is an adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period or the individual differs from the cultural norms prescribed for people of a particular sex. (1)

• Gender role or expression are characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role). While most individuals present socially in clearly masculine or feminine gender roles, some people present in an alternative gender role such as "genderqueer" or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees. (1)

• Gender perception is the way others interpret an individual's gender expression. (7)

• "Genderqueer" is the identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female. (6)

• Genital phenotype is largely determined by androgenic stimulation of the external genitalia in embryonic and fetal life and depends on the presence of the appropriate receptors in the target tissues. (2)

• Gonadal phenotype is defined by the internal genitalia and the external morphology and microanatomy of the gonads (testis or ovary). (2)

• Hormones that express the sexual differentiation in humans include estrogens, progesterone, and androgens, such as testosterone. (6)

• Internalized transphobia describes the discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

• Legal affirmation refers to the changing of gender and name recorded on birth certificate, school records, passports, and other documents. (7)

• Masculinizing hormone therapy for transgender men or transmasculine individuals consists of androgens, such as testosterone. (7)

• Male-to-Female (MtF) describes individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role. (6)

• Natural hormones are derived from natural sources such as plants and animals. Natural hormones may or may not be bioidentical. (6)

• Puberty blockers are gonadotropin-releasing hormone (GnRH) analogues, such as leuprolide and histrelin. (7)

• Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia, also known as "natal gender". When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex. For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth. (1)

• Sexual characteristics are the physical and behavioral traits of an organism. In humans, sex organs or primary sexual characteristics are those an individual is born with. These traits are distinguished from secondary sex characteristics that develop later in life usually during puberty. The development of primary and secondary sexual characteristics is controlled by sex hormones produced in the body after the initial fetal stage, dependent on the presence or absence of the Y-chromosome and/or the testis-determining factor/gene to determine development. (6)

• Sexual orientation refers to an individual's identity relation to the gender(s) to which they are sexually and romantically attracted. (7)

• Social affirmation refers to adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms, including other facilities. (7)

• Surgical affirmation are the surgical/procedural approaches to feminize or masculinize physical features of an individual. (7)

• 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. (6)

• 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. For many people, this involves learning how to live socially in another gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized. (1, 6)

• Trans men assume male gender identities. Trans men have an internal sense of being male and generally seek to make their maleness known socially and legally along with conforming their primary and secondary sex characteristics to a more typical male appearance. (1)

• Transsexualism is a gender dysphoria disorder in which the person manifests, with constant and persistent conviction, the desire to live as a member of the opposite sex and progressively takes steps to live in the opposite sex role full-time. These individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role. (2)

• Transvestism or cross-dressing describes the individual clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex. (5)

• Trans women assume female gender identities. Trans women have an internal sense of being female and generally seek to make their femaleness known socially and legally along with conforming their primary and secondary sex characteristics to a more typical female appearance. (11)

Definitions of Irreversible Chest and Genital Surgical Procedures for Gender Reassignment

• Augmentation mammaplasty – insertion of breast implants or lipofilling (suctioning of body fat from one body area and filling into another body area) to create the female chest.

• Clitoroplasty – creation of a clitoris, utilizing the penile glans.

• Genitoplasty – genital reconstruction or modification of genitalia.

• Hysterectomy/salpingo-oophorectomy – removal of the uterus with or without ovaries and fallopian tubes.

• Metoidioplasty – following testosterone replacement therapy, the clitoris enlarges to be separated from the labia minora to create a penis.

• Orchiectomy – both testicles are removed.

• Penectomy – removal of the penis.

• Phalloplasty – construction or reconstruction of the penis.

• Reconstruction of the fixed part of the urethra – associated surgical reconstruction with the scrotoplasty to create a scrotal complex.

• Scrotoplasty – creation of a penis from external genitalia, such as the labia majora, with or without testicular prosthesis insertion or implant.

• Subcutaneous mastectomy – removal of breast tissue, sparing the nipple-areola complex to create the male chest.

• Vaginectomy – removal of part or the entire vagina.

• Vaginoplasty – construction or reconstruction of the vaginal canal and may include neovaginoplasty, the partial or total construction of the vulvo-vaginal complex.

• Vulvoplasty – a reduction of the labia and may be known as a labiaplasty.

Regulatory Status

Gender reassignment surgical procedures are surgical interventions and, as such, are not subject to regulation by the FDA. The devices and medications/combinations of medications used in the treatment of gender dysphoria are subject to FDA approval or clearance. Refer to the FDA web site at www.fda.gov for additional information on devices and medications that may be utilized for treatment.

Rationale:

This policy was originally created in 2006 and has updated regularly with searches of the MedLine database and the current World Professional Association for Transgender Health (WPATH) Standards of Care (SOC). The most recent literature search was performed through March 2019. The following is a summary of the key literature to date.

Gender Assignment Surgery

The ability to diagnose infants born with intersex conditions has advanced rapidly in recent years. In most cases today, clinicians can promptly make an accurate diagnosis and counsel parents on therapeutic options. However, the paradigm of early gender assignment has been challenged by the results of clinical and basic science research, which show that gender identity development likely begins in utero. While the techniques of surgical genital reconstruction have been mastered, the understanding of the psychological and social implications of gender assignment is poor. (1-3)

Treatment of ambiguous genitalia is controversial. No one debates the need to treat underlying physiologic problems such as those associated with congenital adrenal hyperplasia or tumors in the gonads. However, treatment for ambiguous genitalia depends on the type of disorder but will usually include corrective surgery to remove or create reproductive organs appropriate for the gender of the child. Treatment may also include hormone replacement therapy. Controversy revolves around issues of gender assignment by the physician and family which may not correlate with gender preference by the patient in adulthood. (1-4)

For example, Reilly and Woodhouse interviewed and examined 20 patients with the primary diagnosis of micropenis in infancy and concluded, "[A] small penis does not preclude a normal male role and a micropenis or microphallus alone should not dictate a female gender reassignment in infancy." More particularly, these doctors found that when parents "were well counseled about the diagnosis they reflected an attitude of concern but not anxiety about the problem, and they did not convey anxiety to their children. They were honest and explained problems to the child and encouraged normality in behavior. They believed that this is the attitude that allows these children to approach their peers with confidence. (2-4, 8)

From a medico-legal standpoint, the best approach to managing these cases is to provide parents with as much information as possible so that they can make informed decisions. Adequate counseling and support for parents is vital. The ideal management method is a team approach including neonatologists, geneticists, endocrinologists, surgeons, counselors, and ethicists. (2, 3, 9)

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in March 2019 did not identify any ongoing or unpublished trials that would likely influence this policy.

Professional Guidelines and Position Statements

There are no professional guidelines and position statements that would likely influence this policy.

Section Summary: Gender Assignment Surgery

The available evidence supports the conclusion that psychological, medical, and/or surgical services are required for the treatment of ambiguous genitalia; therefore, considered medically necessary.

Gender Reassignment Surgery

Within the past decade, addressing transgender health care concerns has come to the forefront for inclusion and diversity worldwide. (10) These concerns have transcended to all facets of the lesbian, gay, bisexual, or transgender (LGBT) community, including initiating changes in the health care services offered to the transgender individuals.

In January 2016, ECRI published a special report on gender dysphoria. (12) Their review included 10 publications of systematic reviews and primary studies) targeting puberty suppression therapy, cross-sex hormonal therapy, and sexual reassignment surgery. The following is a summary of their reviews:

• *Puberty Suppression Therapy*: ECRI did not identify any studies that met their review inclusion criteria addressing this topic in the adolescent population.

• *Cross-Sex Hormonal Therapy*: ECRI reviewed 1 systematic review and 3 primary studies. The systematic review reported on 28 studies of 1833 patients (1093 MtF [male-to-female]; 801 FtM [female-to-male]) who received endocrine therapy as part of their sex reassignment treatment -- 80% of the patients demonstrated significant improvements in gender dysphoria; 78% of the patients demonstrated significant improvements in psychological symptoms; 80% of the patients reported significant improvement in quality of life; and 72% of the patients reported significant improvement in sexual function. The primary studies focused on specific issues and resolutions following hormonal therapy: 1) psychological functioning following testosterone treatment for FtM patients; 2) incidence of breast cancer following androgen deprivation and estrogen treatment for MtF; and 3) mood disorders following hormonal treatment starting by age 32.

• *Sexual Reassignment Surgery*: ECRI evaluated 2 systematic reviews and 4 primary studies. One review included 25 studies of patients having undergone MtF penile skin inversion and the bowel vaginoplasty technique, in which the sexual function and patient satisfaction were considered "overall acceptable." The second review indicated that sexual satisfaction was "high"; however, quality of life was not reported. The primary studies focused on patient satisfaction, postoperative complications, psychosocial and sexual well-being, mortality, morbidity, and criminal rates. One study reported higher overall mortality, increased risk of suicide attempts, psychiatric inpatient care, and higher risk of criminal conviction rates. Other studies reported overall satisfaction with surgical procedures, improved mental health, and better quality of life. Postoperative complications were noted in 2 of the studies.

Later in 2016, ECRI released a summary of hormonal treatment with gonadotropin-releasing hormone (GnRH) analogues that can suppress the secretion of luteinizing hormone and follicle-stimulating hormone, being used as a puberty blocker in transgender children and adolescents. (13) The ECRI review indicated the evidence is consistent in showing that GnRH analogues benefit this transgender population by improving symptoms of depression, anxiety, body image, emotional and behavioral problems, and quality of life.

Revisions Following Initial GRS Treatment

Revisions to primary or secondary sexual characteristics should always be interpreted in the context of specific benefit language. The requirement of the presence of a functional impairment for a specific etiology may vary as applied to any physiological condition. It should be noted that the presence of a functional impairment would render treatment medically necessary and thus not subject to contractual definitions of reconstructive or cosmetic.

Reversal Following Regret of GRS Treatment

Misdiagnosed gender dysphoric patients may regret any gender reassignment treatments. Regret following hormonal and surgical treatment was reported at 1.83% in an 8-year case series reported by Judge et al., in 2014, of 218 patients of both transgender sexes. (14) In 2014, Dhejne et al. reported 2.2% (n=15) of the 767 patients over 50 years experienced regrets, but over time, the number of regrets has significantly declined. (15) This study was inclusive of both transgender sexes. Two other studies were reviewed from Krege et al. (16), and Nelson et al. (17), all of which reported 0% reported no regrets following gender reassignment surgery (GRS) treatments.

Seven patients who regretted their decision to undergo MtF sexual reassignment surgery were studied by Djordjevic et al. (18) Following 3 independent psychiatric evaluations for each patient, reversal surgeries were planned: 4 patients completed all steps of reversal, 2 are partially completed and awaiting completion, and 1 patient has declined a portion of the reversal. The reviewers concluded understanding the characteristics of patients regretting GRS will assist future patients opting for these services.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in March 2019 did not identify any ongoing or unpublished trials that would likely influence this policy.

Professional Guidelines and Position Statements

World Professional Association for Transgender Health (WPATH)

WPATH, formerly the Harry Benjamin International Gender Dysphoria Association, is the most widely recognized SOC and have been recognized by national medical and mental health organizations. (1, 5, 6, 10) WPATH states their overall goal to provide clinical guidance for health professionals to assist transsexuals, transgenders, and gender-nonconforming individuals with safe and effective pathways to achieve lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. (5)

In the 2012 WPATH SOC Seventh Version, clarifies the recommended medically necessary GRS and related services as the following: (6)

"In a June 2008 Clarification Statement, WPATH reiterated the procedures which are considered components of sex reassignment by the Standards of Care and specifically stated that these services are considered medically necessary when clinically indicated. WPATH underscores the clinical significance of the full range of reconstructive interventions including non-genital procedures (e.g., breast augmentation, mastectomy and chest reconstruction, facial feminization surgeries, and facial hair removal).

To ensure treatment effectiveness, WPATH emphasizes that individuals must have access to the procedures which match their clinical needs. Individuals may have a clinical need for specific procedures, although not every individual will require surgery or every possible intervention. Coverage must extend to include the variations which may exist for a given surgery type, and permit a multiple stage surgical process, to ensure clinical appropriateness for the individual." (6, 10)

In November 2015, the International Journal of Transgenderism published recommendations for speech-language therapy for individuals seeking the development of voice and communication that reflects their unique sense of gender. (19) The authors acknowledge the WPATH SOC recognition of speech-language congruency of inner and outer self. Davies et al. expand the speech-language recommendations to include the clinical care by professionals that require trans-specific voice-and-communication assessments, voice feminization protocols-and-voice feminizing surgeries, and voice masculinization protocols. (19)

American Psychiatric Association (APA)

In 2012, the APA Task Force published a report on the treatment of gender identity disorder. (20) The APA stated the following:

"There are some level B studies examining satisfaction/regret following sex reassignment (longitudinal follow-up after an intervention, without a control group); however, many of these studies obtained data retrospectively and without a control group (APA level G). Overall, the evidence suggests that sex reassignment is associated with an improved sense of well-being in the majority of cases, and also indicates correlates of satisfaction and regret. No studies have directly compared various levels of mental health screening prior to hormonal and surgical treatments on outcome variables; however, existing studies suggest that comprehensive mental health screening may be successful in identifying those individuals most likely to experience regrets."

American Academy of Pediatrics (AAP)

In 2018, the AAP released a policy statement, with recommendations focused on children and youth that identify as transgender rather than the larger LGBTQ (lesbian, gay, bisexual, transgender, queer) population. (7) The AAP stated that any discrimination based on

gender identity or expression, real or perceived, is damaging to the socio-emotional health of children, families, and society. In particular, the AAP recommends the following, which includes the psychosocial, healthcare

insurer, medical/mental health provider, community, family, auxiliary service, educational, workforce, legal, and federal government aspects of a child or youth seeking gender reassignment services: (7)

1. "That youth who identify as TGD [transgender and gender diverse] have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space";

2. "That family-based therapy and support be available to recognize and respond to the emotional and mental health needs of parents, caregivers, and siblings of youth who identify as TGD";

3. "That electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of each patient while maintaining confidentiality and avoiding duplicate charts";

4. "That insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions";

5. "That provider education, including medical school, residency, and continuing education, integrate core competencies on the emotional and physical health needs and best practices for the care of youth who identify as TGD and their families";

6. "That pediatricians have a role in advocating for, educating, and developing liaison relationships with school districts and other community organizations to promote acceptance and inclusion of all children without fear of harassment, exclusion, or bullying because of gender expression";

7. "That pediatricians have a role in advocating for policies and laws that protect youth who identify as TGD from discrimination and violence";

8. "That the health care workforce protects diversity by offering equal employment opportunities and workplace protections, regardless of gender identity or expression"; and

9. "That the medical field and federal government prioritize research that is dedicated to improving the quality of evidence-based care for youth who identify as TGD".

Centers for Medicare and Medicaid Services (CMS)

In the CMS Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery released in June 2016, CMS stated the following: (21)

"While we are not issuing a NCD [National Coverage Determination], CMS encourages robust clinical studies that will fill the evidence gaps and help inform the answer to the question posed in this proposed decision memorandum. Based on the gaps identified in the clinical evidence, these studies should focus on which patients are most likely to achieve improved health outcomes with gender reassignment surgery, which types of surgery are most appropriate, and what types of physician criteria and care setting(s) are needed to ensure that patients achieve improved health outcomes."

Section Summary: Gender Reassignment Surgery

The criteria in the 2012 World Professional Association for Transgender Health (WPATH) Seventh Version Standards of Care (SOC) are supported by evidence-based peer-reviewed scientific literature. Long-term trials of continuous hormonal therapy and living in one's affirmed gender, as well as social support, acceptance by family and peers, contribute to the improvements to the individual's well-being and health, following gender reassignment surgery (GRS) procedures. Multi-disciplinary mental, medical, surgical, and speech-therapy professionals are crucial towards the best results to match the gender body identity to the intended gender identity role. Therefore, applicable GRS procedures and related services may be considered medically necessary when meeting the coverage criteria and the member's Benefit Contract allowance for these services.

Summary of Evidence

Gender Assignment Surgery

For individuals requiring gender assignment services following birth as a newborn or infant when ambiguity varies to identify their specific sexual gender, the evidence includes a variety of studies over the years, including a statement from the U.S. National Institute of Health. Relevant outcomes following corrective surgery, which may or may not correlate with the patient in adulthood. The evidence is sufficient to provide the psychosocial, medical, and/or surgical services for treatment of ambiguous genitalia.

Gender Reassignment Surgery

For individuals seeking gender reassignment surgery with related services, the evidence primarily includes a globally accepted standard of care, which is supported by evidence-based peer-reviewed scientific literature. Relevant outcomes must include multi-disciplinary mental, medical, surgical, and speech-therapy professionals to achieve the best results to match the individual's gender identity. In accordance with the member's Benefit Contract allowances for these services or Legislative directives, the evidence is sufficient to determine these services result in a meaningful improvement in the individual's net health outcome.

Contract:

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coding:

CODING:

Disclaimer for coding information on Medical Policies

Procedure and diagnosis codes on Medical Policy documents are included only as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, device or diagnosis codes in a Medical Policy document has **no** relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a medical policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT/HCPCS/ICD-9/ICD-10 Codes
The following codes may be applicable to this Medical policy and may not be all inclusive.
CPT Codes
11950, 11951, 11952, 11954, 11980, 11981, 11982, 11983, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15820, 15821, 15822, 15823, 15824, 15825, 15826, 15828, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879, 17380, 19301, 19303, 19304, 19316, 19318, 19324, 19325, 19340, 19342, 19350, 21120, 21121, 21122, 21123, 21125, 21127, 30400, 30410, 30420, 30430, 30435, 30450, 53430, 54125, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54520, 54660, 54690, 55175, 55180, 55970, 55980, 56625, 56800, 56805, 56810, 57106, 57107, 57110, 57111, 57291, 57292, 57295, 57296, 57335, 57426, 58150, 58180, 58260, 58262, 58275, 58280, 58285, 58290, 58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58720, 90845, 90846, 90847, 90849, 90853, 90863
HCPCS Codes
J1071, J2320, J3121, J3145, S0189
ICD-9 Diagnosis Codes
Refer to the ICD-9-CM manual
ICD-9 Procedure Codes
Refer to the ICD-9-CM manual
ICD-10 Diagnosis Codes
Refer to the ICD-10-CM manual
ICD-10 Procedure Codes
Refer to the ICD-10-CM manual

Medicare Coverage:

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. CMS has issued a decision memo and coverage may be subject to an individual claim review.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <http://www.cms.hhs.gov>.

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Policy History:

Date	Reason
5/1/2019	Document updated with literature review. Coverage unchanged. Several definitions added in Description section. Reference 7 added; none removed.

3/15/2018	Document updated with literature review. The following changes were made to coverage: 1) Clarification of the required referrals prior to any surgery or related service(s); 2) The new coverage statements for gender primary or secondary sexual characteristic revision surgeries – "When there is documented evidence of physical functional impairment, gender primary or secondary sexual characteristic revision procedures or services are considered medically necessary. When there is no documented evidence of physical functional impairment, gender primary or secondary sexual characteristics revision services are considered not medically necessary (refer to appropriate procedure-specific policy)"; and, 3) The new coverage statements for reversal of gender reassignment surgical procedures – "Reversal of any of the prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics, the patient must meet the same criteria for gender dysphoria to have those reversal procedures considered medically necessary. If the criteria for gender dysphoria is not met, then reversal of any prior gender reassignment surgical procedure(s) or service(s) for gender primary or secondary sexual characteristics is considered not medically necessary." The following was removed from coverage: 1) "See related medical policies below for information regarding related procedures or services for non-gender reassignment services because other exclusions may apply"; and 2) the listing of all medical policies addressing non-surgical related services and surgical related services.
10/1/2016	Document updated with literature review. Coverage unchanged. Speech-language therapy recommendations included in Rationale.
11/6/2015	Document updated with literature review. Multiple coverage changes from experimental, investigational and/or unproven to medically necessary for primary and secondary gender reassignment surgeries and related services. Coverage statements added for those individuals reaching the age of majority. Rationale and References updated and reorganized.
7/1/2014	Document updated with literature review. Coverage unchanged. CPT/HCPCS code(s) updated.

3/15/2013	Document updated with literature review. Coverage unchanged. The following was added: Gender reassignment surgery and related services, for those members with a contract or a certificate of coverage that would allow for gender reassignment surgery, when specific criteria are met. Title changed from Gender Reassignment Surgery to Gender Assignment Surgery and Gender Reassignment Surgery with Related Services. Policy removed from no further review status.
4/1/2008	Policy reviewed without literature review; new review date only. This policy is no longer scheduled for routine literature review and update.
5/1/2006	New medical document

Archived Document(s):

Title:	Effective Date:	End Date:
Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	03-15-2018	04-30-2019
Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	10-01-2016	03-14-2018
Gender Assignment Surgery and Gender Reassignment Surgery with Related Services	11-06-2015	09-30-2016
Gender Assignment Surgery (GAS) and Gender Reassignment Surgery (GRS) with Related Services	07-01-2014	11-05-2015
Gender Assignment Surgery (GAS) and Gender Reassignment Surgery (GRS) with Related Services	03-15-2013	06-30-2014
Gender Reassignment Surgery	04-01-2008	03-14-2013
Gender Reassignment Surgery	05-01-2006	03-31-2008

APPENDIX H

POLSINELLI

150 N Riverside Plaza, Suite 3000, Chicago, IL 60606-1599 • 312 819 1900

November 6, 2018

William P. Sweeney
(312) 873-3664
(312) 873-4353 Direct Fax
wsweeney@polsinelli.com

VIA EMAIL: ehamburger@sylaw.com

Ms. Eleanor Hamburger
Sirianni Youtz Spoonemore Hamburger
701 Fifth Avenue, Suite 2560
Seattle, WA 98104

Re: C[redacted] P[redacted], Member ID No. [redacted]8820; DOB [redacted]2005

Dear Ms. Hamburger:

As I indicated in my previous correspondence dated October 3, 2018, because Catholic Health Initiatives ("CHI") determined that the handling of your client, C[redacted] P[redacted]'s claim had not met CHI's expectations of its plan vendors, CHI has undertaken a complete review of the adjudication of your client's claim in accordance with the terms of the CHI Medical and Prescription Drug Plan (the "Plan"). Accordingly, CHI has carefully considered the information provided and applied the terms of the Plan to the request for benefits as applicable. For the reasons set out herein, CHI has determined that CVS Caremark has correctly denied this claim.

Under the Plan, a compound medication, such as the medication in question, is only covered if ***all*** ingredients within the compound are included in the Plan's formulary. In this case, your client's request for the compound medication Testosterone Powder Micronized must be denied as ***none*** of the following ingredients: (a) Testosterone Micronized-Powder-100%; (b) Ethoxy Diglycol-Liquid-100%; and (c) HRT Cream Base Women-Cream (g) are covered on the Plan's formulary. Importantly, this denial is in no way related to the fact that this compound is or may be related to transgender health services. The Plan uniformly denies any and all claims for compound medications where at least one ingredient within the compound is not on the Plan's formulary. In this case, and as stated above ***none*** of the ingredients within Testosterone Powder Micronized are found on the Plan's formulary. Note, however, that CVS Caremark has determined and communicated to you and your client other alternative medications that are covered under the Plan.

POLSINELLI

In addition, your letter dated October 1, 2018 requested certain plan documents and records be produced in conjunction with your client's claim including (1) all documents related to the denial, including internal records; and (2) CHI Medical Plan's prescription drug formulary. As your October 31, 2018 email acknowledged, CHI has already produced the formulary in effect in July 2018 and the one that will go in effect in 2019. CHI has now conferred with CVS Caremark, and CVS Caremark has confirmed that it does not have any additional documents, including internal records, related to this claim. As such, CHI and CVS Caremark have provided you or your client with all relevant documents. Notwithstanding the foregoing, although you or your client should have already received all of these documents, in the event that any of the documents within CVS Caremark's claim file have not been previously provided to you from your client, I have enclosed copies herein, as listed below:

- July 13, 2018 Letter from CVS Caremark to the Parent or Legal Guardian of C[redacted] P[redacted] – Notice of Adverse Coverage Determination
- July 18, 2018 Letter from CVS Caremark to the Parent or Legal Guardian of C[redacted] P[redacted] – Request for External Review Preliminary Review
- July 19, 2019 Letter from CVS Caremark to the Parent or Legal Guardian of C[redacted] P[redacted] – Notice of Final Adverse Coverage Determination
- August 6, 2018 Letter from CVS Caremark to C[redacted] P[redacted]
- September 25, 2018 Letter from CVS Caremark to Ms. Eleanor Hamburger

Your letter dated October 1, 2018 also asserts that CVS Caremark's previous correspondence, "provides no information about (a) how to submit a request for external review, nor (b) any of the required information about his appeal rights and timelines under ERISA." Upon a thorough review of all correspondence sent by CVS Caremark to your client, we have determined that in fact CVS Caremark has provided all relevant instructions for initiating a request for external review. For example, in the "Notice of Final Adverse Coverage Determination" dated July 19, 2018, CVS Caremark provided the following information[1]:

[1] This information was likewise provided on CVS Caremark's Notice of Adverse Coverage Determination dated July 13, 2018.

POLSINELLI

How do I ask for an external review? You must submit a request for external review within four months after receiving this notice. External review requests must be clearly identified as an "external review" when submitted. You may submit the request, in writing, along with any documents that show why the drug should be approved. Your request should include the member's name, contact information (including mailing address and daytime phone number), member ID number and a copy of this letter. If we have contact information for the entity that processes external reviews for your plan, it is listed below. If not, please contact your benefits office.

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

Who may ask for an external review? You or your prescriber may ask for an external review. You may also have a relative, friend, advocate, or anyone else (including an attorney) act on your behalf as your authorized representative.

How long will it take to receive a decision? For a standard external review, a decision will be made within 45 days of receiving your request. An external review request that meets the definition of urgent under the law will be reviewed and a decision made as soon as possible, but no later than 72 hours after the external reviewer receives the request. In the event that state requirements are stricter, the time to review and make a decision on your case will be modified to comply with the applicable state requirements.

Any additional information regarding the external review, including the specific documentation required for the external review, will be provided as soon as your client requests such external review as described above.

Finally, I have also received your October 31, 2018 email requesting the "2019 plan" for your client. CHI has not yet drafted documents for the 2019 plan year. As a result we are unable to provide you with any additional plan documents at this time. Along with your request for 2019 plan documents, your email states "please indicate whether transgender health services will continue to be excluded in the 2019 plan." To reiterate, the claim in question was not denied due to any relation it may or may not have to transgender health services. Moreover, neither CHI, nor the CHI medical or prescription drug plans make coverage decisions based on a particular service being considered a "transgender health service." The Catholic Church supports the position that fundamental rights of transgendered persons must be defended and everyone must strive to eliminate any form of injustice, oppression or violence against them. As a result, in 2019, the only "transgender health service" specifically excluded under the Plan is gender reassignment surgery, as this surgery has been determined not to align with the teachings and doctrine of the Catholic Church.

POLSINELLI

Your client has now exhausted the internal claims and appeal procedures under the Plan. Pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), your client has the right to bring a civil action under ERISA Section 502(a) within twelve (12) months of the date that your client submitted the initial claim. For more information, including information about the time limit that the Plan imposes on bringing a civil action, please refer to your client's benefit plan materials. Alternatively, you or your client may contact the plan administrator.

In the event that you have any additional questions regarding this claim, please do not hesitate to contact me directly.

Sincerely,

William P. Sweeney

WPS:seg
Enclosures

cc: Catholic Health Initiatives

APPENDIX I

THE POLYCLINIC

THE POLYCLINIC DOWNTOWN FAMILY MEDICINE

509 Olive Way, Suite 900
Seattle WA 98101
Phone: 206-860-4700
Fax : 206-624-9520

7/11/2019

C[redacted] R[redacted] P[redacted]
[redacted]
Bremerton WA 98310
DOB: [redacted]/2005

To Whom It May Concern,

I am writing this letter on behalf of the patient named above. This patient has been established in my office since September 2016. By way of introduction I, Kevin Hatfield MD, am a specialist in transgender medicine and healthcare issues and follow over 850 transgender and gender variant patients in my clinical practice.

This patient has a long-standing medical diagnosis of gender dysphoria/transgender identity. (F64.0) This patient has been on testosterone therapy since early 2018. He has been living his life socially and academically as a male since early 2015. He has functioned well with his male gender identity without any hesitation and exhibits all usual signs of being well-adjusted in his male gender role. The only ongoing issue and the one for which I am writing this letter is the patient's gynecomastia which requires chest reconstruction surgery not only because of his transgender status but also because his gynecomastia remains an ongoing concern in public for personal safety and comfort when passing as "male" among his peers. The patient's gender identity disorder has not been alleviated or minimized to a significant degree despite testosterone therapy and living his life as a male because of his breast prominence and the dysmorphia this creates.

The patient has been in counseling regarding gender identity and he is otherwise free of any other comorbid psychiatric conditions. He is a very well adjusted and otherwise healthy male with no other health concerns. His gender dysphoria is primarily rooted in ongoing issues with gynecomastia and medically my concern as a transgender medicine specialist physician is to advocate for this surgical intervention so that he can live his life as a male without compromise or self imposed activity restrictions either out of concern for personal safety or due to physical limitations.

This patient has already changed his gender marker of birth, and his legal name, Social Security Number and Passport. He is compliant with all medical recommendations for therapy and I would envision an excellent outcome for him after chest reconstruction surgery. His parents are extremely supportive and agree with my recommendations for him to pursue this surgery. He is an excellent and appropriate candidate in all respects for this life changing gender affirming surgical intervention.

Sincerely,

MD

Kevin S Hatfield, MD
Personally reviewed and electronically signed

APPENDIX J

CENTER For CHILD And FAMILY THERAPY, P.C., INC.

Bremerton
7500 Old Military Rd. NE, Suite 103
Bremerton, WA 98311

Port Orchard
104 Tremont, Suite 201
Port Orchard, WA 98366

(360) 698-9258
FAX (360) 698-9296
E-mail: admin@ccftherapy.com
www.ccftherapy.com

July 24, 2019

Dr. Kyllo
1229 Madison St. #1600
Seattle WA 98104

Re: C[redacted] R[redacted] P[redacted] DOB [redacted]2005

Dear Doctor Kyllo,

I am writing this letter on behalf of C[redacted] P[redacted] to document that he is a good candidate for chest reconstruction surgery as the next step in his gender confirmation process. I met with C[redacted] and his mother for one hour and C[redacted] by his self for one hour as preparation to write this assessment letter. C[redacted] has had a long standing diagnosis of F64.0, gender dysphoria/transgender identity since September 2016. He has been receiving treatment by Dr. Hatfield at the Polyclinic in Seattle, initially in 2016, for hormone blockers and followed by testosterone hormone therapy. I also reviewed Dr. Hatfield's assessment letter which details how C[redacted] meets the criteria for chest reconstructive surgery as outlined by the World Professional Association for Transsexual, Transgender and Nonconforming Gender Health. I received confirmation from C[redacted] and his mother, that C[redacted] had been living his life socially and academically for the past four and a half years and that he had received hormone blockers and followed by testosterone hormone therapy during the past four years. C[redacted] and his mother also reported that C[redacted] has also legally changed his name and gender marker of birth. They appeared to educated in what they could expect with the outcome of chest reconstructive therapy. They are planning for C[redacted] to have the surgery during Christmas break of 2019, so that it does not conflict with him playing tennis and so there is sufficient recovery time before C[redacted] needs returned to school.

I observed C[redacted] to be emotionally and mentally well adjusted in his gender identity and to be free of any psychosis, disturbance in personality or impaired judgment. Given that C[redacted]'s insight and judgment are within normal range, and he has the support and guidance of his parents, it is anticipated he will be compliant with the surgeon's prescribed pre-care and aftercare recommendations for surgery. C[redacted] appears to be a well adjusted

male other than his long established history of gender dysphoria. Chest reconstructions surgery will eliminate the need for C[redacted] to wear a chest binder which can lead to pulmonary atrophy and exercise compromise with long term use. I have assessed C[redacted] to be an appropriate candidate for this gender affirming surgical intervention.

It recommended that C[redacted] receive counseling if and mood, social problems or other issues arise. Please feel free to contact me with any questions.

Sincerely,

Sharon Booker

Sharon Booker, MA L.M.H.C.

APPENDIX K

Blue Cross Blue Shield of Illinois
PO Box 805107
Chicago, IL 60680-4112

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**********MIXED AADC 983
3037 1 MB 0.428 5
TO THE PARENT OR GUARDIAN OF C[redacted]
P[redacted]
[redacted]
BREMERTON WA 98310[redacted]

Number: C20051
iber ID: [redacted]8820
Name: C[redacted] P[redacted]

08/08/2019

Dear Kevin Hatfield,

Thank you for your recent inquiry. We have reviewed the information submitted and determined the proposed procedure, J9225 (Vantas implant), is a contract exclusion. No benefits are available for the procedure.

If you have any questions, please feel free to contact us at (800) 972-8088, between the hours of 8:00 AM and 6:00 PM, Central Time, Monday through Friday.

Sincerely,

Your Customer Advocates
Blue Cross Blue Shield of Illinois
This is a courtesy copy for your records.

IMPORTANT INFORMATION
(Retain for your records)

This document applies to your Blue Cross and Blue Shield of Illinois group or individual policy. If you are receiving this notice and your plan is self-insured, your plan may have elected to follow the external review procedure below. Any conflicts between the statements below and rights stated elsewhere in this notice (or in your policy or Benefit Plan), will be resolved so that those rights that are more beneficial to you will apply, unless the law requires otherwise.

If we have denied your claim for benefits, in whole or in part, for a requested treatment or service, rescinded your coverage, or denied or limited your eligibility (if applicable), then this document serves as part of your notice of an adverse determination. Contact us at the number on the back of your ID card if you need assistance understanding this notice or your adverse determination.

Your Internal Appeal Rights

What if I don't agree with this decision? You have a right to appeal an adverse determination. However, you only have 180 days from the date you receive the notice of adverse determination to file an internal appeal.

Who may file an internal appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may designate an authorized representative by completing the necessary forms. For more information on how to do so, contact us at the number on the back of your ID card.

How do I file an internal appeal? For claim appeals, you may contact us at the number on the back of your ID card and request an internal appeal or send a written request.

If your insurance is offered through your employer, send your request to:
Claim Review Section
Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, Illinois 60690

If you purchase your insurance directly from Blue Cross and Blue Shield of Illinois, send your request to:
Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744
Fax: (888)235-2936

What about eligibility-related denials and recissions? Please refer to your benefit booklet for additional specifics. You may also contact us at:

Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744
Phone: (800)538-8833
Fax: (888)235-2936

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted within 24 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor you experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal. Some urgent situations may also qualify for an expedited external review, as described below.

Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information once you initiate your appeal. You may also have the option of presenting evidence and testimony. In addition, we may provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination so you have a reasonable opportunity to respond before a final decision is made.

Can I request copies of information relevant to my claim? Yes, you may request and receive copies relevant to your claim free of charge. For example, upon request, you may receive the diagnosis and treatment codes (and their corresponding meanings) associated with an adverse determination. In addition, if we rely on a rule or guideline (such as a provision excluding certain benefits within your policy booklet) in making an adverse determination, we may provide that rule or guideline to you free of charge upon request. You can request copies of this information by contacting us at the number on the back of your ID card.

What happens next? If you appeal, we will review our decision and send you a written determination.

You External Review Rights

You may have the right to have our decision to deny a request or claim based on a determination of medical necessity, experimental/investigation status of the recommended treatment, the condition being considered pre-existing or a health care coverage rescission reviewed by an Independent Review Organization (IRO) if (1) we continue to deny the partial or full payment of a claim, coverage, or eligibility for benefits and you have exhausted your internal appeal rights, (2) you have not received an internal appeal decision within 30 days of a review for pre-certification or 60 days of a review for a service previously rendered, or within 48 hours for urgent situations, or (3) your situation qualifies for an expedited external review, as described below. You must file a request for an external review within 4 months after you receive notice of the denial of the claim or appeal.

What qualifies for an expedited external review? You may be eligible for an expedited external review (1) if the failure to obtain treatment in the time necessary to complete a standard external review would seriously jeopardize your life, health or ability to regain maximum function, (2) in connection with emergency services prior to your discharge from a facility or (3) if you are requesting treatment that is experimental or investigational and your health care provider certifies in writing that such treatment would be significantly less effective if not promptly initiated.

How do I request external review? You or your authorized representative may request an expedited external review by notifying the Illinois Department of Insurance by phone (toll-free number (877)850-4740). You or your authorized representative may also file a request for either expedited or standard external review by completing the required forms available at www.insurance.illinois.gov/externalreview and submitting them directly to the address noted below. Blue Cross and Blue Shield of Illinois will also provide the forms upon request.

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, Illinois 62767
Fax: (217)557-8495
Email: DOI.externalreview@illinois.gov

Once an eligible request for external review is complete, the matter will be randomly assigned by the Illinois Department of Insurance to an IRO approved by the Department. There will be no charge to you for the IRO review. The IRO will notify you and your authorized representative of its decision, which will be binding on BlueCross and BlueShield of Illinois, and on you except to the extent you have additional remedies available. Until July 2013, you can appeal the decision of an IRO by filing an appeal with the Illinois Department of Insurance.

Other Resources to Help You

For questions about your rights, this notice, or for assistance, you can contact the Illinois consumer assistance program.

Illinois Department of Insurance
100 Randolph Street 9th Floor
Chicago, IL 60601
www.insurance.illinois.gov
Telephone: (877) 527-9431
Email: DOI.Director@illinois.gov

You may be eligible to receive your adverse determination and this notice in a language listed below. In addition, you may call us to receive assistance in these languages.

SPANISH (Español): Para asistencia en Español, por favor llame al numero ubicado en la parte posterior de su tarjeta de identificación.

TAGALOG (Tagalog): Upang humingi ng tulong sa Tagalog, paki tawagan ang numero na nakasulat sa inyong kard.

CHINESE (中文): 如果需要中文幫助，請撥打您卡上的電話號碼。

NAVAJO (Dine): Dinék'ehjí áka'a'doowoołbiniiyé, t'áá shǫǫdi koji' hodiilnih béésh bee haane'í bi numbo bee nééh ho'dólzinigii biniiyé nanitinigii bine'dęę' bikáá'

BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

APPENDIX L

Blue Cross Blue Shield of Illinois
PO Box 805107
Chicago, IL 60680-4112

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**********MIXED AADC 983
3036 1 MB 0.428 5
TO THE PARENT OR GUARDIAN OF C[redacted]
P[redacted]
[redacted]
BREMERTON WA 98310[redacted]

Number: C20051
iber ID: [redacted]8820
Name: C[redacted] P[redacted]

08/08/2019

Dear Jeffrey Kyllo,

Thank you for your recent inquiry. We have reviewed the information submitted and determined the proposed procedure, 19303 (Mastectomy simple complete), is a contract exclusion. No benefits are available for the procedure.

If you have any questions, please feel free to contact us at (800) 972-8088, between the hours of 8:00 AM and 6:00 PM, Central Time, Monday through Friday.

Sincerely,

Your Customer Advocates
Blue Cross Blue Shield of Illinois
This is a courtesy copy for your records.

IMPORTANT INFORMATION
(Retain for your records)

This document applies to your Blue Cross and Blue Shield of Illinois group or individual policy. If you are receiving this notice and your plan is self-insured, your plan may have elected to follow the external review procedure below. Any conflicts between the statements below and rights stated elsewhere in this notice (or in your policy or Benefit Plan), will be resolved so that those rights that are more beneficial to you will apply, unless the law requires otherwise.

If we have denied your claim for benefits, in whole or in part, for a requested treatment or service, rescinded your coverage, or denied or limited your eligibility (if applicable), then this document serves as part of your notice of an adverse determination. Contact us at the number on the back of your ID card if you need assistance understanding this notice or your adverse determination.

Your Internal Appeal Rights

What if I don't agree with this decision? You have a right to appeal an adverse determination. However, you only have 180 days from the date you receive the notice of adverse determination to file an internal appeal.

Who may file an internal appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may designate an authorized representative by completing the necessary forms. For more information on how to do so, contact us at the number on the back of your ID card.

How do I file an internal appeal? For claim appeals, you may contact us at the number on the back of your ID card and request an internal appeal or send a written request.

If your insurance is offered through your employer, send your request to:
Claim Review Section
Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, Illinois 60690

If you purchase your insurance directly from Blue Cross and Blue Shield of Illinois, send your request to:
Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744
Fax: (888)235-2936

What about eligibility-related denials and recissions? Please refer to your benefit booklet for additional specifics. You may also contact us at:

Blue Cross and Blue Shield of Illinois
P.O. Box 3122
Naperville, Illinois 60566-9744
Phone: (800)538-8833
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What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted within 24 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor you experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal. Some urgent situations may also qualify for an expedited external review, as described below.

Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information once you initiate your appeal. You may also have the option of presenting evidence and testimony. In addition, we may provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination so you have a reasonable opportunity to respond before a final decision is made.

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What happens next? If you appeal, we will review our decision and send you a written determination.

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You may have the right to have our decision to deny a request or claim based on a determination of medical necessity, experimental/investigation status of the recommended treatment, the condition being considered pre-existing or a health care coverage rescission reviewed by an Independent Review Organization (IRO) if (1) we continue to deny the partial or full payment of a claim, coverage, or eligibility for benefits and you have exhausted your internal appeal rights, (2) you have not received an internal appeal decision within 30 days of a review for pre-certification or 60 days of a review for a service previously rendered, or within 48 hours for urgent situations, or (3) your situation qualifies for an expedited external review, as described below. You must file a request for an external review within 4 months after you receive notice of the denial of the claim or appeal.

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How do I request external review? You or your authorized representative may request an expedited external review by notifying the Illinois Department of Insurance by phone (toll-free number (877)850-4740). You or your authorized representative may also file a request for either expedited or standard external review by completing the required forms available at www.insurance.illinois.gov/externalreview and submitting them directly to the address noted below. Blue Cross and Blue Shield of Illinois will also provide the forms upon request.

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, Illinois 62767
Fax: (217)557-8495
Email: DOI.externalreview@illinois.gov

Once an eligible request for external review is complete, the matter will be randomly assigned by the Illinois Department of Insurance to an IRO approved by the Department. There will be no charge to you for the IRO review. The IRO will notify you and your authorized representative of its decision, which will be binding on BlueCross and BlueShield of Illinois, and on you except to the extent you have additional remedies available. Until July 2013, you can appeal the decision of an IRO by filing an appeal with the Illinois Department of Insurance.

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100 Randolph Street 9th Floor
Chicago, IL 60601
www.insurance.illinois.gov
Telephone: (877) 527-9431
Email: DOI.Director@illinois.gov

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BlueCross BlueShield of Illinois

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TTY/TDD: 855-661-6965
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U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

APPENDIX M

SIRIANNI YOUTZ
SPOONEMORE HAMBURGER PLLC

December 2, 2019

BY CERTIFIED MAIL/
RETURN RECEIPT REQUESTED

Claims Review Section
Blue Cross Blue Shield of Illinois
P.O. Box 2401
Chicago, IL 60690

RE: *C[redacted] P[redacted], Member ID No. [redacted]8820; DOB [redacted]2005*

To Whom It May Concern:

I represent C[redacted] P[redacted] and his parents Patricia and Nolle Pritchard. The Pritchards received a denial of coverage from Blue Cross Blue Shield of Illinois dated August 8, 2019 for a Vantas Implant (J 9225) and a mastectomy (19303) for C[redacted]. Both procedures are required to treat C[redacted]'s medical diagnosis of gender dysphoria/transgender identity (F64.0). Please consider this letter to be an appeal of the denial of coverage by Blue Cross Blue Shield of Illinois ("BCBSIL"), the claims administrator, and Catholic Health Initiatives Medical Plan ("CHI Plan"), the Plan through which C[redacted] receives his health coverage.

Consistent with the requirements of the Affordable Care Act, including Section 1557, both BCBSIL and the CHI Plan have separate but equivalent legal and fiduciary duties to provide C[redacted] with coverage for medically necessary transgender health treatment, under the terms and conditions of the Plan, as modified by the ACA. Neither entity can discriminate against C[redacted] and similarly situated enrollees by, in the case of the CHI Plan, designing a discriminatory benefit exclusion, or, in the case of BCBSIL, administering such a discriminatory exclusion. Both the CHI Plan and BCBSIL are liable to provide this coverage. Ultimately, C[redacted] and his parents do not care which entity covers C[redacted]'s treatment, so long as it is covered as required by law.

I. BACKGROUND

C[redacted] P[redacted] is male. His birth certificate, legal name, social security information and passport all reflect his male identity. *See Exhs. 1, 26* and *27*. He is well-adjusted and healthy except for his gender dysphoria, which his treating physician notes is "rooted in ongoing issues with gynecomastia." *Exh. 1*. As Dr. Hatfield opines, this surgical intervention is medically necessary, so that C[redacted] can live his life as male

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without compromise or self-imposed activity restrictions stemming from his gynecomastia. *Id.*

The CHI Plan and BCBSIL have covered much of C[redacted]'s treatment leading to this request for coverage of gynecomastia/chest reconstruction and a second Vantas Implant. BCBSIL, however, has denied C[redacted]'s request for pre-authorization of this treatment. *See Exhs. 3, 4.*

A. Coverage of C[redacted]'s First Vantas Implant.

C[redacted] has lived his life as male since 2015. *See Exh. 5.* On October 14, 2016, his mother was informed by BCBSIL that coverage for a Vantas implant was approved. *Exh. 6.* C[redacted] received his first implant on November 11, 2016. *See Exh. 7.*

After receiving the implant, Mr. Pritchard and his mother received conflicting information about coverage for the procedure. C[redacted]'s providers were paid by BCBSIL, but the Pritchards were told by BCBSIL representatives that coverage was denied. *Id.; Exh. 10.* On April 21, 2017, Ms. Pritchard received a letter from BCBSIL stating that "treatment for transgender services were allowed incorrectly under the medical plan." *Exh. 8.* The same letter indicated that "[f]or any future transgender services, benefits will not be covered under the medical plan." *Id.* No clawback of the payments occurred.

On May 25, 2017, the Pritchards appealed the written denial. *Exh. 7.* On October 19, 2017, the Pritchards received a notice from BCBSIL with the subject line: "We're reviewing your appeal." *Exh. 9.* The letter indicated that the appeal had been received on June 2, 2017 and indicating that a decision would be made within 15 calendar days of the date received, or by June 17, a date that had long passed. *Id.*

No formal response was provided to the Pritchards' appeal until BCBSIL sent a letter dated April 26, ***2018***, eleven months after the appeal was submitted. *See Exh. 11.* That letter denied coverage of the service, identified as "Services related to Gender-reassignment" as "not a benefit of contract." *Id.* The denial letter referred to the April 21, 2017 letter and claimed that because services related to gender-reassignment were not expressly listed as covered in the Plan, the services were excluded. *Id.*

Starting on January 1, 2018, the CHI Plan added an express exclusion of "Transgender Reassignment Surgery." The Exclusion states "[b]enefits shall not be provided for treatment, drugs, medicines, therapy, counseling services and supplies for or leading to gender reassignment surgery." *See* 2018 CHI Plan, p. 61.

B. Coverage of Testosterone Powder Micronized.

C[redacted] has been prescribed and requires testosterone cream for treatment of his gender dysphoria. On May 30, 2018, the Pritchards received a denial of coverage for the medication from CVS/Caremark on behalf of the Plan. *Exh. 12.* The reason given was as follows:

> We are unable to approve your request for reimbursement because the drug for which you are requesting reimbursement is not on your plan's Formulary (the list of prescription drugs we cover).

Id. The letter did not include a copy of the formulary, and did not indicate that the medication was excluded as part of the Plan's exclusion of all services related to transgender health. *See id.*

The Pritchards appealed the denial of coverage related to the testosterone cream. They received ***four*** different letters on July 23, 2018, which contained conflicting information about their appeal. *Exhs. 13-16.*

The first letter, dated July 19, 2018, denied coverage of the medication claiming that the medication was excluded under the CHI Plan:

> Your request for coverage of Testosterone Powder Micronized is denied. Your pharmacy benefit plan does not cover Testosterone Powder Micronized. Plan exclusion. You may refer to the prescription benefit drug section in your Explanation of Coverage document for guidelines used in making this decision. Reviewed by – JL 07/19/2018 01:48 PM.

Exh. 13. The first letter indicates that the "actual benefit provision, guidelines, protocol or other similar criterion used to make the decision" could be requested from BCBSIL. *Id.* The letter informed the Pritchards that they had the right to seek external review of the decision.

The second letter, also dated July 19, 2018, stated that the Testosterone Powder Micronized is denied because it was a compounded medication that included an excluded ingredient:

> Ingredient TESTOSTERONE MICRONIZED-POWDER-100%, ETHOXY DIGLYCOL-LIQUID-100% and HRT CREAM BASE WOMEN-CREAM (G) are not covered under your pharmacy benefit plan and you are responsible for the cost of the non-covered ingredient. You may refer to the prescription drug benefit section in your Explanation of Coverage document for guidelines used in make this decision. Reviewed by - JL, 0719.2018 -1:48 pm - AD, 07/19/2018 01:57 PM.

Exh. 14. Again, the letter indicated that BCBSIL would provide a copy of the actual benefit provision, guideline or protocol used to make the decision upon request. *Id.* No copy of the formulary was provided.

A third letter dated July 18, 2018, from CVS/Caremark indicated that an independent external review of the denial of Pritchard's medication had been requested. *Exh. 15.* The letter stated that the appeal had been forwarded to an independent external review to determine whether the case qualified for review. *Id.*

A fourth letter dated July 19, 2018 from Network Medical Review Co. Ltd. stated that the "appeal is not eligible for independent external review because it does not involve either medical judgment or a rescission of coverage." *Exh. 16.*

A few days later, a ***fifth*** letter was received by the Pritchards, also dated July 18, 2018, indicating that they had not exhausted the administrative appeals process because a second level appeal was required and had not been completed. *Exh. 17.* The letter indicated that another second level appeal would be processed.

On July 31, 2018, in order to clarify the basis for the denial and the status of the request, the Pritchards requested a complete copy of the appeals file related to the request for the testosterone medication, including the specific benefit provision, guideline, protocol or other criterion upon which the decision was based, all internal communications related to the appeal and all information considered or relied upon by the Plan when making the decision. *Exh. 18.*

In response, CVS/Caremark provided a single letter dated August 6, 2018 that stated that it contained "further clinical information about why your appeal was denied" ***without actually containing any additional information.*** *See Exh. 19.* Mrs. Pritchard called CVS customer service and was told that "it was a mistake in the letter to say there was something else included.... [T]estosterone is not covered due to a plan exclusion."

On August 27, 2018, the undersigned counsel wrote CVS/Caremark and BCBSIL seeking clarification as to the specific exclusion upon which the denial of coverage for C[redacted]'s testosterone was based and all documents related to his appeal. *Exh. 20.* On September 28, 2018, CVS/Caremark provided an unsigned letter that ignored the requests made in the August 27, 2018 letter. *Exh. 21.* No internal records were provided. The September 28, 2018 letter stated that two of the five letters received had been sent incorrectly, but failed to identify which letters were incorrect. The letter maintained that coverage had ***not*** been denied due to C[redacted]'s gender, and, for the first time, CVS/Caremark identified other forms of testosterone medication that could be covered. *Id.*

Shortly thereafter, a letter dated October 3, 2018 was provided to the undersigned by the CHI Plan's counsel, William P. Sweeney of the Polsinelli Law Firm. Mr. Sweeney represented that an investigation of the claims would be undertaken. *See Exh. 22.*

On November 6, 2018, Mr. Sweeney wrote the undersigned to report on CHI's investigation of the bases for denial of C[redacted]'s testosterone medication. *Exh. 23.* Mr. Sweeney stated that the testosterone medication was not denied due to the fact that the medication was related to transgender health services. *Id.*, p. 1. Mr. Sweeney also explained that a different form of testosterone medication would be covered under the Plan.

Mr. Sweeney's letter explained that the CHI Plan language would be narrowly applied in 2019: "[I]n 2019, the only 'transgender health service' specifically excluded under the Plan is gender reassignment surgery." Mr. Sweeney did not describe the specific surgery or surgeries that the Plan considers to be "gender reassignment surgery" nor is that term defined in the 2019 CHI Plan.

The letter did not resolve the dispute, but C[redacted] and his parents determined that he could receive coverage for testosterone medication as an injection (although the syringes were not covered). C[redacted] received this coverage despite the "gender reassignment" exclusion in the CHI Plan.

C. C[redacted]'s Treating Physician Prescribes a Second Vantas Implant and Gynecomastia/Chest Reconstruction Surgery.

In July 2019, C[redacted] and his parents met with Dr. Hatfield and later with C[redacted]'s therapist, Sharon Booker, about his request for gynecomastia and chest reconstruction. All of the medical providers consulted concluded that the surgery is medically necessary. *See Exhs. 1, 2.* The providers submitted the requests for both the surgery and the second Vantas Implant. Both were denied by BCBSIL. *See Exhs. 3, 4.*

This appeal is timely submitted.

II. ARGUMENT

A. The Treatment C[redacted] Seeks Is Not "Gender Reassignment Surgery" and Must Be Covered.

The 2019 CHI Plan excludes benefits for "gender reassignment surgery." *Exh. 24.* The term "gender reassignment surgery" is not defined in the CHI Plan. *See id.* The medical procedures sought by C[redacted] are not "gender assignment surgery" but rather a second Vantas implant, and gynecomastia and chest reconstruction. *See Exhs. 3, 4.* The procedures are not genital surgery, and they will not "reassign" C[redacted]'s gender or sex.

From a legal perspective, C[redacted]'s gender has already been changed to male. His birth certificate, passport, school records, etc. all identify him as male. *Exhs. 1, 27* and *28.* The medical treatment C[redacted] seeks will not result in "reassignment." Rather, the medical treatment is medically necessary to conform his physical condition to his actual

legal identity, and to allow him to live as a male without unnecessary restriction. *See Boyden*, 341 F. Supp.3d at 987; *Exh. 1.*

In any event, the term "gender reassignment surgery" is ambiguous, particularly in light of the coverage that the CHI Plan has provided to treat C[redacted]'s gender dysphoria. *See Kunin v. Benefit Tr. Life Ins. Co.*, 910 F.2d 534, 541 (9th Cir. 1990); *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948, 950 (9th Cir. 1993) (in both, the terms "mental disorder" and "mental illness" were ambiguous since they were not defined by the Plan document).

The ambiguity of this language in the CHI Plan language is an ERISA violation. Under ERISA, participants must be able to readily ascertain their rights simply from reading the Plan documents. *Cinelli v. Sec. Pac. Corp.*, 61 F.3d 1437, 1445 (9th Cir. 1995). Hidden terms or unidentified exclusions are improper. *See Cent. Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 743, 124 S. Ct. 2230 (2004) ("There is no doubt about the centrality of ERISA's object of protecting employees' justified expectations of receiving the benefits their employers promise them.").[1] 29 C.F.R. §2520.102-3(l) (An SPD must contain "a statement clearly identifying circumstances which may result in … denial … of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits"); *see also* 29 C.F.R. § 2520.102-3(j) (The SPD must include a description of whether and under what circumstances preventive services, medical tests, devices and procedures are covered, as well as any conditions or limits on specialty care). The term "gender reassignment surgery" is impermissibly vague and fails to convey whether and under what circumstances treatment for gender dysphoria will be covered or excluded. The conflicting history of claims submitted by C[redacted] and his parents for treatment confirms it. *See* Section I above. The procedures requested on C[redacted]'s behalf should be covered since they are not and do not lead to "gender reassignment surgery."

[1] *See Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899, 905 (9th Cir. 2009) (recognizing that the doctrine of reasonable expectations may apply to self-funded plans); *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 387 (9th Cir. 1994) (Exclusions must be "clear, plain and conspicuous" or else they violate the doctrine of reasonable expectations).

B. Even if the Procedures Are "Gender Reassignment Surgery," the Exclusion Violates Section 1557 of the ACA, As Written and As Administered.

The Affordable Care Act's Section 1557 prohibits covered health entities, including both CHI ***and*** BCBSIL from designing and administering discriminatory health benefits. 42 U.S.C. § 18116(a). Courts have repeatedly concluded that Section 1557 prohibits blanket exclusions of all coverage for transgender health, particularly where the same treatment is covered for individuals of different genders.

For example, a similar exclusion was challenged in *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis. 2018). In that case, the public employee benefit coverage for Wisconsin state employees contained an exclusion of all "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment." *Id.* at 987. Like CHI and BCBSIL here, the defendants in *Boyden*, contended that the exclusion did not apply to "hormone therapy or mental health counseling when used to treat gender dysphoria ***unless*** specifically made [in] a course of treatment ***leading to or involving gender confirming surgery.***" *Id.* (emphasis in the original). In *Boyden*, the federal district court found defendants liable for discrimination, ruling that "[t]he Exclusion on its face treats transgender individuals differently on the basis of sex, thus triggering the protections of Title VII and the ACA's anti-discrimination provision." *See also, Flack v. Wis. Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1015 (W.D. Wis. 2019) (similar exclusion in Wisconsin Medicaid discriminates based on sex); *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 953 (D. Minn. 2018) (Section 1557 prohibits discrimination on the basis of gender identity).

Importantly, the *Boyden* court concluded that the surgeries considered by the Wisconsin public employee benefit coverage to be "gender reassignment surgeries" were the same procedures used to treat other medical conditions in women. *Id.*, 341 F. Supp. 3d at 989. The same is true here, according to BCBSIL's own medical policies. *See e.g., Exhs. 28* and *29*. It is discrimination to provide coverage for medically necessary mastectomies for cisgender women, while excluding coverage for the same procedure when medically necessary to treat transgender men. The "gender reassignment surgery" exclusion in C[redacted]'s BCBSIL/CHI Plan is facially discriminatory.

SIRIANNI YOUTZ
SPOONEMORE HAMBURGER PLLC

1. CHI Has No "Religious Freedom" to Discriminate.

CHI's lawyer, Mr. Sweeney, wrote that the "gender reassignment surgery" exclusion was put in place because coverage of such procedures was "determined not to align with the teachings and doctrine of the Catholic Church." *Exh. 23.* Mr. Sweeney ignored CHI's obligation as a "covered health entity" under the Affordable Care Act to provide health benefits without discrimination. *See* 42 U.S.C. § 18116(a); *Exh. 25.*

There is no "religious freedom" exception to Section 1557. Under the plain language of Section 1557, only the "grounds of" and "enforcement mechanisms" from Title IX were incorporated into the new law. *See* 42 U.S.C. § 18116(a). Congress's choice of words is presumed to be deliberate. *United States v. Motamedi*, 767 F.2d 1403, 1406 (9th Cir. 1985). "The plain meaning of these two sentences combined is clear and unambiguous – claims for discrimination are available on the grounds prohibited in the four listed federal civil rights statutes and are to be addressed under the … corresponding enforcement mechanisms of the four statutes." *York v. Wellmark, Inc.*, 2017 U.S. Dist. LEXIS 199888, at *52 (S.D. Iowa Sep. 6, 2017). These are the only elements imported into Section 1557, precisely because Congress did not intend to allow broader exemptions into the ACA. CHI must provide coverage for health benefits without discrimination.

2. BCBSIL May Not Administer A Discriminatory Exclusion.

Similarly, BCBSIL is a "covered health entity" under the ACA, and is subject to its non-discrimination requirements. 42 U.S.C. § 18116(a); *see Exhs. 3, 4* (both denials include non-discrimination notifications required by Section 1557). BCBSIL cannot claim that it is just a third-party administrator ("TPA") that followed CHI's order to include the "gender reassignment surgery" exclusion. TPAs are liable when they administer plans in a manner that violates Section 1557.

The plaintiffs in *Boyden* brought a lawsuit against both the employer/plan ***and*** the TPA. *Id.*, at 997-998. The federal district court concluded that a TPA is a proper defendant in a lawsuit pursuant to Section 1557. *Id.; see also Boyden v. Conlin*, 2018 U.S. Dist. LEXIS 79753, at *11 (W.D. Wis. May 11, 2018) (same). *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 954 (D. Minn. 2018) (same). This is consistent with longstanding ERISA case law. *See Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770

F.3d 1282, 1297-1298 (9th Cir. 2014), *cert. denied,* 2015 U.S. LEXIS 6538 (Oct. 13, 2015) (plan administrators that improperly deny or cause an improper denial of benefits are proper defendants under ERISA).

BCBSIL, as the plan administrator, cannot "just follow orders" to administer an illegal exclusion at CHI's request. BCBSIL had an independent statutory, regulatory, contractual and fiduciary duty to the participants and beneficiaries of the CHI Plan to administer benefits in a non-discriminatory manner. *See N.Y. State Psychiatric Ass'n v. UnitedHealth Grp.*, 798 F.3d 125, 133 (2d Cir. 2015) (ERISA § 502(a)(3) imposes a fiduciary duty on a claims administrator to comply with the Parity Act while administering claims). When CHI sought to add the "gender reassignment surgery" exclusion, BCBSIL knew it was illegal. *See Exh. 28,* p.1 (recognizing that such an exclusion was a form of illegal discrimination). BCBSIL had a choice to make. It could either (1) keep CHI's business and administer the Exclusion despite its clear-cut violation of Section 1557; (2) refuse to administer the CHI Plan altogether; (3) administer the Plan in a manner that complied with Section 1557, *e.g.*, refuse to administer the illegal Exclusion and instead authorize such coverage when medically necessary;[2] or (4) seek guidance from the courts under ERISA §502, 29 U.S.C. §1132(a)(2). *See Wong v. Bacon,* 445 F. Supp. 1177, 1185, 1977 U.S. Dist. LEXIS 12166, *18-19 (N.D. Cal. 1977). BCBSIL apparently chose Option #1, placing its own financial interests, and the general interests of CHI above those of the participants it had a duty to protect. This decision is the very essence of a breach of fiduciary duty under ERISA. *See* 29 U.S.C. §1104(a)(1).

In sum, BCBSIL cannot administer a discriminatory exclusion merely because CHI pays BCBSIL to do so. Any contract between BCBSIL and CHI that directs the BCBSIL to apply a discriminatory exclusion in violation of Section 1557 is an illegal contract. *See Kaiser Steel Corp. v. Mullins,* 455 U.S. 72, 77, 102 S. Ct. 851 (1982)("[N]o court will lend its assistance in any way towards carrying out the terms of an illegal contract."). BCBSIL cannot avoid liability for discrimination by claiming that it was just following orders.

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[2] This is, of course, what happened when BCBSIL approved coverage of C[redacted]'s first Vantas implant. *See Exh. 6.*

SIRIANNI YOUTZ
SPOONEMORE HAMBURGER PLLC

III. CONCLUSION

C[redacted] P[redacted] has been denied a Vantas implant for a second time, and coverage for gynecomastia and chest reconstruction. Neither procedure is "gender reassignment surgery." Neither will result in a "reassignment" of his gender, which, as a matter of law, is male.

But even if the procedures result in "gender reassignment," they must still be covered pursuant to 42 U.S.C. § 18116(a). Both BCBSIL and CHI Plan have a legal, contractual, and fiduciary duty to C[redacted] to design and administer benefits in a non-discriminatory manner. The denial of coverage of both the Vantas implant and the recommended gynecomastia and chest reconstruction is a form of gender discrimination.

Please do not hesitate to call me if you have any questions about this letter. I can be reached at 206-838-1809.

Very truly yours,

SIRIANNI YOUTZ
SPOONEMORE HAMBURGER PLLC

Eleanor Hamburger

Eleanor Hamburger sh

EH:sh
Enclosures
cc: Denise Diskin
Clients

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SIRIANNI YOUTZ
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Certified Fee	3.50
Return Receipt Fee (Endorsement Required)	2.80
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$ 22.40

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Street, Apt. No.; or PO Box No.: BCBSIL P.O. Box 2401
City, State, ZIP+4: Chicago IL 60690

PS Form 3800, August 2006 See Reverse for Instructions

PRIORITY MAIL ★

DATE OF DELIVERY SPECIFIED*
USPS TRACKING™ INCLUDED*
INSURANCE INCLUDED*

7012 0470 0000 8056 3319

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02 7H 0001234624 MAILED FROM ZIP CODE 98121

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APPENDIX N

BlueCross BlueShield of Illinois

December 23, 2019

Subscriber:	Patricia Pritchard
Group/Sub. No.:	[redacted]3820
Claim No.:	Pre-Service Benefit Determination
Appeal ID No.:	[redacted]0472
Appeal Type:	Member's Authorized Representative

Patricia Pritchard
[redacted]
Bremerton WA 98310[redacted]

Phone: (866)776-4244
Fax: (918)551-2011
Email: SDOAppeals@bcbsil.com

Subject: Your appeal request

Dear Patricia Pritchard,

We have your appeal request for the service(s) below.

Based on your plan, our prior response dated April 26, 2018 completed the internal appeal process that is available to you. Please refer to our final decision letter for any additional rights that you may have.

Appeals Request	Reconsideration of Surgical Procedure		
Member	C[redacted] P[redacted]	Provider	Kevin Hatfield, M.D.
Service Date(s)	Pre-Service Benefit Determination	Facility	The Polyclinic
Initial Decision	This service is not a benefit of the contract (provision is not covered).	Initial Decision Code	299
Initial Decision Date	April 21, 2017	Claim Amount	$0.00

If you have questions or to request copies, please contact Customer Service at the number above.

Sincerely,

Shannon H
Appeals Specialist II

BlueCross BlueShield of Illinois

December 23, 2019

Subscriber:	Patricia Pritchard
Group/Sub. No.:	[redacted]8820
Claim No.:	Pre-Service Benefit Determination
Appeal ID No.:	[redacted]0472
Appeal Type:	Member's Authorized Representative

Patricia Pritchard
[redacted]
Bremerton WA 98310-[redacted]

Phone: (866)776-4244
Fax: (918)551-2011
Email: SDOAppeals@bcbsil.com

Appeals Department

Cc: The Polyclinic
Kevin Hatfield MD

Attachment:
IL02.G.UGF.F

APPENDIX O

BlueCross BlueShield of Illinois

CLAIMS CENTER - Claim Detail

Member Information

Member name: C[redacted] P[redacted]
Group number: [redacted]
ID number: [redacted]

Claim Information

Claim number: [redacted]
BCBS status: Paid
Last update date: 02/12/2020
Claim type: Medical
Claim group: Add to Claim Group
Create a Claim Group to better manage and view your claims.

Provider Information

Provider name: KEVIN HATFIELD
Date of service: 11/06/2019

Claim Payment Summary

The amount shown under "Amount You May Owe" will reflect costs not covered by your plan.

Below is a summary that shows how your claim was billed. The rates you agreed on with your doctor or hospital may vary from the amount billed.

Questions about what your plan covers? Check your plan documents. Or call us at the number on your member ID card.

A table displaying your billed amount, BCBS Discount and 3rd Party Payments, coinsurance paid by plan, your responsibility, and the amount you may owe from top to bottom.

Billed Amount	**$7,593.00**
Network Discount	$2,967.06
BCBS Discount & 3rd Party Payments	**- $2,967.06**
Coinsurance Paid By Plan	**- $2,536.36**
Applied Deductible	$1,244.13
Your Coinsurance	+ $845.45
Your Responsibility	**$2,089.58**
Amount You May Owe:	**$2,089.58**

Service Line Details

Below are the details for services performed that are related to this claim and any other details on record.
A table displaying the service date, service description, amount billed by provider, network discount, amount not covered, amount covered, amount paid by plan, and amount of your responsibility from left to right.

Service Date	Service Description	Billed by Provider	Network Discount	Covered Amount	Paid by Plan	Your Responsibility
11/06/2019	Drugs	$6,963.00	$2,845.00	$4,118.00	$2,536.36	**$1,581.64**
11/06/2019	Surgery	$630.00	$122.06	$507.94	-	**$507.94**
	Totals	$7,593.00	$2,967.06	$4,625.94	$2,536.36	$2,089.58

BlueCross BlueShield of Illinois

CLAIMS CENTER - Claim Detail

Member Information

Member name: C[redacted] P[redacted]
Group number: [redacted]
ID number: [redacted]

Claim Information

Claim number: [redacted]
BCBS status: Processed
Last update date: 11/14/2019
Claim type: Medical
Claim group: Add to Claim Group
Create a Claim Group to better manage and view your claims.

Provider Information

Provider name: KEVIN HATFIELD
Date of service: 11/06/2019

Claim Payment Summary

The amount shown under "Amount You May Owe" will reflect costs not covered by your plan.

Below is a summary that shows how your claim was billed. The rates you agreed on with your doctor or hospital may vary from the amount billed.

Questions about what your plan covers? Check your plan documents. Or call us at the number on your member ID card.

A table displaying your billed amount, BCBS Discount and 3rd Party Payments, coinsurance paid by plan, your responsibility, and the amount you may owe from top to bottom.

Billed Amount	**$153.00**
Network Discount	$71.07
BCBS Discount & 3rd Party Payments	**- $71.07**
Coinsurance Paid By Plan	**- $0.00**
Applied Deductible	$81.93
Your Responsibility	**$81.93**
Amount You May Owe:	**$81.93**

Service Line Details

Below are the details for services performed that are related to this claim and any other details on record.
A table displaying the service date, service description, amount billed by provider, network discount, amount not covered, amount covered, amount paid by plan, and amount of your responsibility from left to right.

Service Date	Service Description	Billed by Provider	Network Discount	Covered Amount	Paid by Plan	Your Responsibility
11/06/2019	Laboratory Services	$73.00	$33.65	$39.35	-	**$39.35**
11/06/2019	Laboratory Services	$80.00	$37.42	$42.58	-	**$42.58**
	Totals	$153.00	$71.07	$81.93	$0.00	$81.93

BlueCross BlueShield of Illinois

CLAIMS CENTER - Claim Detail

Member Information

Member name: C[redacted] P[redacted]
Group number: [redacted]
ID number: [redacted]

Claim Information

Claim number: [redacted]
BCBS status: Processed
Last update date: 11/09/2019
Claim type: Medical
Claim group: Add to Claim Group
Create a Claim Group to better manage and view your claims.

Provider Information

Provider name: KEVIN HATFIELD
Date of service: 11/06/2019

Claim Payment Summary

The amount shown under "Amount You May Owe" will reflect costs not covered by your plan.

Below is a summary that shows how your claim was billed. The rates you agreed on with your doctor or hospital may vary from the amount billed.

Questions about what your plan covers? Check your plan documents. Or call us at the number on your member ID card.

A table displaying your billed amount, BCBS Discount and 3rd Party Payments, coinsurance paid by plan, your responsibility, and the amount you may owe from top to bottom.

Billed Amount	**$15.00**
Network Discount	$11.64
BCBS Discount & 3rd Party Payments	**- $11.64**
Coinsurance Paid By Plan	**- $0.00**
Applied Deductible	$3.36
Your Responsibility	**$3.36**
Amount You May Owe:	**$3.36**

Service Line Details

Below are the details for services performed that are related to this claim and any other details on record.
A table displaying the service date, service description, amount billed by provider, network discount, amount not covered, amount covered, amount paid by plan, and amount of your responsibility from left to right.

Service Date	Service Description	Billed by Provider	Network Discount	Covered Amount	Paid by Plan	Your Responsibility
11/06/2019	Laboratory Services	$15.00	$11.64	$3.36	-	**$3.36**
	Totals	$15.00	$11.64	$3.36	$0.00	$3.36

JS 44 (Rev. 10/20)

CIVIL COVER SHEET

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

I. (a) PLAINTIFFS

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD

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

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Eleanor Hamburger, SIRIANNI YOUTZ SPOONEMORE HAMBURGER PLLC
3101 Western Ave., Ste. 350, Seattle, WA 98121
Tel. 206-223-0303; Email: ehamburger@sylaw.com

DEFENDANTS

BLUE CROSS BLUE SHIELD OF ILLINOIS

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

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

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

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

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

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

Click here for: Nature of Suit Code Descriptions.

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

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

TORTS

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

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

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

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

PRISONER PETITIONS

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

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

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

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

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

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

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

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

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

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

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

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
Patient Protection and Affordable Care Act, Section 1557, 42 U.S.C. § 18116

Brief description of cause:
Seeking injunctive and other remedies for discrimination based on sex

VII. REQUESTED IN COMPLAINT:

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

DEMAND $

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

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
11/23/2020

SIGNATURE OF ATTORNEY OF RECORD
/s/ Eleanor Hamburger

FOR OFFICE USE ONLY

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

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

Western District of Washington

C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD,

Plaintiff(s)

v.

BLUE CROSS BLUE SHIELD OF ILLINOIS

Defendant(s)

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)*

BLUE CROSS BLUE SHIELD OF ILLINOIS
300 East Randolph Street
Chicago, IL 60601

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Eleanor Hamburger
SIRIANNI YOUTZ SPOONEMORE HAMBURGER PLLC
3101 Western Avenue, Suite 350, Seattle, WA 98121
Tel. (206) 223-0303; Fax (206) 223-0246
Email: ehamburger@sylaw.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc: