DECLARATION OF JULIA MCKEOWN

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	No. 1:19-cv-00272-LCB-LPA **DECLARATION OF JULIA MCKEOWN**

I, Julia McKeown, hereby state as follows:

1. I am a plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am a 45-year-old transgender woman. I am employed by North Carolina State University ("NCSU"). I live in Apex, North Carolina.

3. I was designated male at birth, but my gender identity is female. I live in accordance with my female gender identity in all aspects of my life.

4. I have struggled with gender dysphoria since childhood. I had to suppress my gender identity for much of my early life into adulthood. I was first diagnosed with what was then called gender identity disorder in my mid-teens.

5. I grew up and went to school in Florida. During my time in Florida, I completed my higher education, including a bachelor's degree, two master's degrees, and a doctoral degree. During this time, I was also battling severe, untreated gender dysphoria.

While I presented as female in my personal life starting in college, I did not present as female in my professional life for fear that I would experience discrimination.

6. After completing my doctorate, I reached the point where I could no longer suppress who I really was. I made the life-saving decision to live authentically, in accordance with my gender identity, in all aspects of life. Between 2010 and 2016, I was progressing in my career, life, and transition.

7. In 2016, I accepted a position with NCSU and moved to North Carolina from Florida. Since 2016, I have been employed by NCSU as an Assistant Professor in the Teaching Education and Learning Design Department of the NCSU College of Education. I currently teach in the Learning, Design, and Technology Program. I also serve as the Graduate Coordinator for the Learning, Design, and Technology Program.

8. As a North Carolina state employee, I am enrolled in the North Carolina State Health Plan for Teachers and State Employees ("NCSHP"), and receive health care benefits from this plan as part of my compensation. I contribute each month to the plan via a paycheck deduction. I pay the same amount for this coverage as other employees, even though I receive inferior coverage because of the exclusion for gender-affirming care.

9. Once I moved to North Carolina, I started the medical part of my transition. While hormone therapy and social transition have been important aspects of my transition, I was still dealing with significant distress related to gender dysphoria. By 2018, my medical provider referred me for vaginoplasty, as part of treatment for my gender

dysphoria. After consulting with a surgeon, my surgeon and I requested preauthorization for vaginoplasty on or around July 19, 2018.

10. On or around July 23, 2018, the preauthorization was denied because of the reinstatement of the Exclusion of gender-confirming health care in the NCSHP. A true and correct copy of that notice of denial is attached as Exhibit A. Specifically, the notice from Blue Cross and Blue Shield of North Carolina ("BCBSNC") indicated my preauthorization was denied due to an exclusion in the policy, which stated, "Treatment or studies to or in connection with sex changes or modifications and related care." Exhibit A at 2 (KADEL00312897).

11. I appealed that decision to BCBSNC but was informed that they only administer the plan and could not resolve the issue. I also filed a grievance with the NCSHP Section 1557 Coordinator after the denial of preauthorization on or around August 13, 2018. Exhibit A at 1 (KADEL00312896). The grievance was denied on or around September 12, 2018. A true and correct copy of that denial is attached as Exhibit B (KADEL00311967).

12. At that point in my life, I could no longer wait for surgery. Left with no other options, I made the difficult decision to withdraw funds from my retirement and savings accounts, in order to pay for my medically necessary surgery. The surgery was life-changing. I felt like my physical body was finally aligned with who I really was, and I was able to life a more authentic, fulfilling life. The relief the surgery provided me from my gender dysphoria was critical for my wellbeing.

13. As part of my treatment for gender dysphoria, I was also prescribed hormone therapy, which is excluded under the NCSHP. My cost of gender affirming care that was not covered by insurance exceeded $13,000.00.

14. The Exclusion also prohibits me from seeking future medically necessary gender-confirming health care, such as ongoing hormone therapy and additional surgery I may need, such as a mammoplasty.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: 11/19/2021

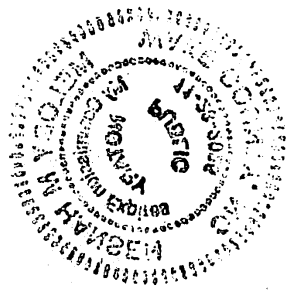
Julia McKeown

Subscribed and sworn before me, a Notary Public in and for the _____,

State of North Carolina, this 19 day of November, 2021.

MELODY M HANSEN NOTARY PUBLIC WAKE COUNTY, NC My Commission Expires 11-28-2025

Signature of Notary



CERTIFICATE OF SERVICE

I certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to all registered users.

Dated: November 30, 2021

/s/ Amy E. Richardson
Amy E. Richardson
N.C. State Bar No. 28768
HARRIS, WILTSHIRE & GRANNIS LLP
1033 Wade Avenue, Suite 100
Raleigh, NC 27605-1155
Telephone: 919-429-7386
Facsimile: 202-730-1301
arichardson@hwglaw.com

Counsel for Plaintiffs

Exhibit A

Julia McKeown
[redacted]
August 12th, 2018

Chris Almberg
Compliance Officer and Section 1557 Coordinator
North Carolina State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

RE: Grievance for Discrimination: Benefits Denial and exclusions based on sex.

Dear Chris Almberg:

As the designated coordinator for Grievances involving discrimination for the North Carolina State Health Plan, please accept this letter as my formal letter of complaint regarding denial of benefits (pre-authorization) of a medically necessary and documented surgical procedure.
On July, 23rd, 2018 I received a letter from Blue Cross Blue Shield indicating an adverse benefit determination for pre-authorization for surgery. I have attached a copy of this letter, which also includes the case and reference number, as well as my insurance ID number. The letter indicated that I was denied due to an exclusion in the policy which stated, "*Treatment or studies to or in connection with sex changes or modifications and related care*". Citing this inclusion for my procedure is in clear violation of several federal laws and as cited seems to be completely based on sex. I reviewed the surgery code and determined that the code was correct as submitted: 55970, Intersex Surgery.

I filed a complaint with BCBSNC and they indicated that since they only service the plan for the state that my complaint must be directed to the NC State Health Plan, which is the purpose of this letter.

My desired remedy is simply to have the State Health Plan and by extension BCBSNC approve and pay for these medically necessary procedures according to my schedule of benefits. To exclude these necessary procedures based on my medical situation is nothing less than a discriminatory action specifically targeting me and denying benefits based on my sex. I do hope this issue can be resolved amicably. Should you need additional information, please let me know. I give permission, to the extent required to address this grievance, to access to my health insurance information, and specifically the documents that were submitted as part of this claim, which includes documentation from three medical professionals regarding these surgical procedures.

Sincerely,
Julia McKeown

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

BlueCross BlueShield of North Carolina
Healthcare Management and Operations
P.O. Box 2291
Durham, NC 27702

Telephone Number: 800-672-7897
Fax Number: 800-672-6587
Website: WWW.BCBSNC.COM

JULIA MCKEOWN
[redacted]

Date of Notice: July 23, 2018

This document contains important information that you should retain for your records.

This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the enclosures to this letter for information about your appeal rights.)

Case Details:

Member/Patient Name: JULIA MCKEOWN
ID Number: [redacted]

Provider: KEELEE MACPHEE, MD
Facility: NORTH CAROLINA SPECIALTY HOSPITAL
Service: Surgical Stay
Date(s) of Service: 9/18/2018 - 9/19/2018
Service: INTERSEX SURGERY; MALE TO FEMALE
Date(s) of Service: 9/18/2018 - 9/19/2018

Reference #: 112412394

Reason for Denial: The requested service is not a covered benefit per your benefit booklet or plan documents.

Explanation of Basis for Determination:

The following is not a covered benefit: Treatment or studies to or in connection with sex changes or modifications and related care.

Sincerely,

Healthcare Management and Operations

cc: KEELEE MACPHEE, MD
cc: NORTH CAROLINA SPECIALTY HOSPITAL

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Exhibit B

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA

3200 Atlantic Avenue • Raleigh, NC 27604 • Phone: 919-814-4400 • Fax: 919-814-5817 • www.shpnc.org

Chris Almberg
Compliance Officer
North Carolina State Health Plan
3200 Atlantic Avenue
Raleigh, NC 27604

September 12, 2018

Julia McKeown
[redacted]

Ms. McKeown,

On August 13, 2018, you submitted a grievance letter by email pursuant to the North Carolina Department of State Treasurer (Department) policy, "Section 1557 Grievance Procedure." In this letter, you alleged that the basis for denying a benefit to you was your sex, and requested that the North Carolina State Health Plan (Plan) approve and pay for the denied benefit.

As required by Department policy, I, in my role as 1557 Coordinator for the Department, have conducted a thorough investigation of your complaint. This letter should be considered my formal written decision on your grievance, based on a preponderance of the evidence.

Section 135-48.30 of the North Carolina General Statutes delineates the powers and duties of the State Treasurer with regards to the Plan. It states, in part, that the Treasurer has the power and duty to set benefits for the Plan. N.C.G.S. § 135-48.30(a)(2). The Board of Trustees of the State Health Plan (the Board) has the power and duty to, "Approve benefit programs, as provided in § 135-48.30(a)(2)." N.C.G.S. § 135-48.22. These powers and duties outlined by statute allow the Treasurer, with approval of the Board, to set benefits for the Plan. Setting benefits for the Plan, by nature, includes the power to exclude benefits from coverage. Any benefit excluded from coverage will not be preauthorized by or paid for by the Plan.

On December 2, 2016, the Board voted in favor of covering the treatment of gender dysphoria, including treatment or studies regarding sex changes or modifications, psychological assessments, and psychotherapy treatment, for the 2017 plan year only.

To date, the Board has not voted on whether to cover these items beyond December 31, 2017. Therefore, treatment or studies to or in connection with sex changes or modifications and related care are not covered benefits for the 2018 plan year. These exclusions are listed in the 2018 Benefit Booklet, which was provided to all members in 2017. These exclusions are applied consistently to all Plan members.

You and your medical providers submitted a preauthorization request for intersex surgery; male to female, to the Plan's third party administrator, BlueCross BlueShield of North Carolina (BCBSNC), on or about July 19, 2018 with dates of service of September 18-19, 2018. The preauthorization request was denied because, per the 2018 Benefit Booklet, the requested service is not a covered benefit. You and your providers were informed of this denial by a notice of adverse benefit determination sent by BCBSNC dated July 23, 2018.

Title IX states that no person shall be subjected to discrimination on the basis of sex under any education program or activity receiving Federal financial assistance. Section 1557 of the Affordable Care Act applies the Title IX prohibition on sex discrimination to health programs or activities that receive federal financial assistance. The United States Courts of Appeal do not agree

about whether gender identity is included in the definition of sex in the Title IX context. Some courts have determined that the term "sex" as used in Title IX and its implementing regulations is ambiguous. Other courts have determined found that the plain language definition of "sex" in Title IX is clear and unambiguous. In addition, an injunction set forth by the United States District Court in Texas prohibits the United States Department of Health and Human Services (HHS) from promulgating rules that include gender identity within the definition of sex discrimination.

As a result, based upon all available information, I cannot conclude that excluding treatment of gender dysphoria, including treatment or studies regarding sex changes or modifications, psychological assessments and psychotherapy treatment as a covered benefit is discrimination on the grounds of sex in this case.

If you wish to appeal this decision, you may do so by writing to the Executive Administrator of the State Health Plan within 15 days of receiving this decision. The Executive Administrator shall issue a written decision in response to the appeal no later than 30 days after its filing. If you wish to appeal this decision, please address your appeal as follows:

Dee Jones, Executive Administrator
North Carolina State Health Plan
Department of State Treasurer
3200 Atlantic Avenue
Raleigh, NC 27604

The availability and use of this grievance procedure does not prevent you from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age, or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights.

You can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Or by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

Or by phone: 1-800-368-1019

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Such complaints must be filed within 180 days of the date of the alleged discrimination.

Sincerely,

Chris Almberg
North Carolina State Health Plan
Compliance Officer

DECLARATION OF C.B.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	No. 1:19-cv-00272-LCB-LPA **DECLARATION OF C.B.**

I, C.B., do hereby state as follows:

1. The initials of my legal name are C.B. I am a plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am a boy.

3. I am 16 years old. I was born and raised in Chapel Hill, North Carolina and currently live there with my family.

4. I am transgender, which means that I was designated "female" at birth, even though I am and identify as male.

5. I am a junior in high school. I enjoy swimming, video games, cars, and hanging out with my friends. In school, I particularly enjoy studying psychology and while I have not yet decided what I will study in college, I am considering psychology as a possible career path.

6. Ever since I was a young child, I have known that I am boy. I was always uncomfortable wearing stereotypically female clothing and would try to dress in a more masculine manner. For example, as a child, I recall refusing to go to school one day because my mom wanted me to wear jeans that had pink stitching on them, which made them feel like girl's jeans. I also recall since I was six or seven years old, refusing to wear stereotypically female swimming suits, opting instead to wear board shorts and a shirt.

7. In late 2016, when I was 11 years old, I began to wear a short, typically masculine haircut, which made me feel more like myself.

8. Knowing that I am a boy, in January 2017, while I was in sixth grade, I recall telling my mom that "I'm not a girl."

9. My mom was supportive and asked me if I wanted to tell my dad and my sister, which I asked her to do on my behalf.

10. After I came out to my parents and informed them that I am transgender, my parents and I began meeting with a therapist in the Spring of 2017.

11. At the time, I was anxious about beginning female puberty, so after consultation with my parents and therapist, I asked to be placed on treatment to delay puberty.

12. During the summer of 2017, I began living as male by informing friends and family of my male gender identity and my new more typically male name, wearing traditionally masculine clothes, and living openly as the boy I am.

13. However, as my chest began to develop, I began to experience additional anxiety.

14. In August 2017, I met a team of medical and mental health professionals at the Duke Gender Clinic, where I was diagnosed with gender dysphoria and was prescribed puberty delaying medication, which was delivered through an implant. The implant lasts about 18 months.

15. The treatment of my gender dysphoria has helped reduce my anxiety, and I feel more comfortable knowing I am developing consistent with who I am.

16. In the Spring of 2018, I legally changed my name to the more typically masculine name that I currently have. Soon after I got a U.S. passport that accurately reflects who I am by having a male sex designation. My driver's license, which I obtained later, also reflects the same.

17. As the year 2019 and the 18-month period for my implant approached, I recall observing my parents worry about how they would pay for my medical care.

18. My parents, who love and support me, have gone to great lengths to shield me from any discrimination, but as I have grown older, that discrimination has become more apparent to me.

19. For example, I am aware that the reason I observed my parents worrying about how they would pay for my care is because the North Carolina State Health Plan for Teachers and State Employees, in which I am enrolled through my father, excludes

coverage of gender-confirming care. It made me feel unhappy and really bad to see my parents experience stress over how they would pay for my care.

20. As a result of the Health Plan's exclusion, not only did my parents have to spend a lot of money, but in early 2019, I was forced to switch from the implant to injection shots as a form of puberty delaying medication. Switching from the implant to shots caused me a great deal of frustration, not only because the injections were painful, but because I also ended up developing cysts as a result of the injections on two separate occasions.

21. In March 2019, I also began taking testosterone as hormone therapy for my gender dysphoria. Hormone therapy has brought me a great deal of relief. For example, I am happy with my voice and the fact that I have to shave now.

22. It is my understanding that the Health Plan refuses to cover my hormone therapy as treatment for my gender dysphoria.

23. It makes me feel bad knowing that a whole group of people, including myself, are being discriminated against for something that they cannot control, being transgender. It makes me feel like we are being treated as different and less than.

24. For as long as I can remember, I have always felt gender dysphoria which I understand to be discomfort and distress due to my body not matching who I am. This dysphoria also causes me anxiety. However, the treatment for gender dysphoria with puberty delaying medication and now hormones, has reduced that anxiety and helped me feel better.

I declare under the penalty of perjury that the foregoing is true and correct.

Dated this 24 day of November, 2021.

CMB [redacted] C.B.

C.B.

Subscribed and sworn before me, a Notary Public in and for the Chatham County,

State of NC, this 24 day of November, 2021.

MARGARET E. ASHNESS NOTARY PUBLIC CHATHAM COUNTY, NC

Signature of Notary

5/12/2026

5

DECLARATION OF MICHAEL D. BUNTING, JR.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	No. 1:19-cv-00272-LCB-LPA **DECLARATION OF MICHAEL D. BUNTING, JR.**

Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

1. I am a plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am the father of Plaintiff C.B., a 16-year-old boy. I live in Chapel Hill, North Carolina.

3. I was a long-term employee of the University of North Carolina at Chapel Hill ("UNC"). I retired from UNC in April 2019.

4. I was employed fulltime by UNC for 28 and a half years, beginning in September 1990 until my retirement in April 2019. My last position with UNC was Associate Athletic Director for Facilities Planning.

5. As a retired North Carolina state employee, I am enrolled for health coverage through the North Carolina State Health Plan. I enrolled in the NCSHP effective October 1, 1990 as a state employee. As my dependent, C.B. is also enrolled in health coverage through NCSHP.

6. C.B., my son, is a boy. He is also transgender. C.B. was designated "female" at birth but has a male gender identity. C.B. is a junior in high school.

7. As I look back, I believe that C.B. has always understood himself to be a boy.

8. Ever since he was a young child, even when he was as young as six years old, C.B. would reject stereotypically female clothing and would dress in a more masculine manner. In late 2016, he began wearing a short, typically masculine haircut.

9. Though C.B. always got along with people and has many friends, he exhibited high levels of anxiety and depressive behaviors that concerned me as his father. C.B. exhibited low grade anger and a short temper over innocuous things, as well as a general unhappiness. His mother and I later came to understand that these behaviors were associated with C.B.'s untreated gender dysphoria.

10. In early 2017, C.B. informed us that he was transgender. It was evident that the knowledge of his true identity was a burden he had carried for many years, causing his anxiety and depressive behavior. C.B.'s openness about his gender appeared to be very freeing for him.

11. Soon after, C.B., his mother, and I, met with a therapist in April 2017. After consultation with the therapist, C.B. asked to be placed on treatment to delay the onset of puberty, which was causing him anxiety.

12. In April of 2017, C.B., Ms. Bunting and I, sought an appointment with the Duke Child and Adolescent Gender Care Clinic ("Duke"), ultimately scheduled for August 2017.

13. During the summer of 2017, C.B. socially transitioned to living as his true self, informing friends and family of his male gender identity, wearing more masculine clothes, and living openly as the boy he is. However, as his breasts began to develop during the summer, C.B. began to experience additional anxiety.

14. As a result of the distress associated with his birth-designated sex, C.B. was diagnosed with gender dysphoria. In August 2017, C.B. began obtaining care from medical and mental health professionals and was prescribed puberty-delaying treatment, in the form of an implant, as part of his treatment for gender dysphoria.

15. Following the beginning of C.B.'s treatment, we noticed that the anxiety he had been experiencing diminished and that he was now a more happy, outgoing, and personable teenage boy.

16. C.B. is treated and known as a boy at school and in all other aspects of his life. He legally changed his name to his current more typically male name in the Spring of 2018.

17. Because in 2017 the NCSHP did not contain an exclusion for gender-confirming health care, C.B.'s puberty-delaying treatment was covered by the NCSHP.

18. C.B.'s puberty-delaying implant only lasted 12 to 18 months. Accordingly, C.B. needed the implant to be removed and replaced in early 2019.

19. However, in mid-2018, Ms. Bunting learned of the reinstitution of the Exclusion of coverage for gender-confirming care within the NCSHP.

20. Worried that we could not afford out-of-pocket the puberty-delaying treatment that C.B. needed, Ms. Bunting and I communicated with the NCSHP Board of Trustees, urging them to once again eliminate the Exclusion of gender-confirming health care within the NCSHP, with no success.

21. Without coverage, the puberty-delaying implant for C.B. would have cost thousands of dollars.

22. In mid-December 2018, following the lack of action by the NCSHP Board of Trustees at their December 2018 meeting to eliminate the Exclusion, Ms. Bunting and I decided to purchase an additional health insurance plan with that would cover puberty-delaying treatment for C.B. Through the federally run ACA health care exchange we purchased a separate insurance plan for C.B. from Blue Cross Blue Shield of North Carolina. Though C.B. and I remained enrolled in the NCSHP and will continue to do so, purchasing additional coverage for C.B. was necessary in order for my family to

be able to afford C.B.'s gender-confirming care. As a result, Ms. Bunting and I had to pay an additional monthly premium and a $6,750.00 deductible for C.B., separate and apart from C.B.'s existing coverage under the NCSHP.

23. In early 2019, C.B. began obtaining puberty-delaying treatment via injection, rather than a longer-lasting implant, because that was the only puberty-delaying treatment on the formulary of the additional health insurance purchased to supplement the coverage under the NCSHP. In March 2019, C.B. also began obtaining hormone therapy as treatment for his gender dysphoria.

24. The additional costs associated with C.B.'s gender-confirming care and the lack of coverage under the NCSHP due to the discriminatory Exclusion were a significant contributing factor in my decision to retire from UNC in 2019.

25. At the time of my decision to retire, Ms. Bunting and I had just learned of the Exclusion and were faced with a potential medical bill for hormone blockers in excess of $29,000 that we did not know how we could afford. I retired and took another job in an effort to increase my income sufficiently to better afford C.B.'s gender-confirming care.

26. C.B. and I remain enrolled in the NCSHP as a dependent and retiree, respectively, following my retirement on April 1, 2019. C.B. now receives masculinizing hormone therapy as part of his gender-confirming care, which he began in 2019. While

the family no longer purchases separate ACA coverage for C.B., C.B.'s hormone therapy is not covered by the NCSHP and we must pay for that care out-of-pocket.

27. As a retired North Carolina state employee, I am enrolled in the NCSHP and receive health care benefits from this plan as part of my compensation. As a dependent of mine, C.B. is also enrolled in the NCSHP. I contributed $700 each month to the plan this past year. Even though I receive inferior coverage because of the Exclusion for gender-affirming care, I pay the same amount towards coverage as other members of the NCSHP.

28. The lack of access to coverage through the state health plan has been a serious barrier at different points to helping C.B. be happy and healthy, and has imposed significant stress on our family.

29. The Exclusion discriminates against and stigmatizes C.B. as a transgender person which has impacted me and my family financially and emotionally, causing us to experience ongoing stress, anxiety, and uncertainty. I lost countless hours of sleep worrying for my son, who I love and support, and how we would pay for his gender-confirming care. Further, the uncertainty caused by the Exclusion contributed in large part to me, a lifelong Tar Heel, leaving my dream job at UNC.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: November 22, 2021

Michael D. Bunting, Jr.

Subscribed and sworn before me, a Notary Public in and for the Orange County, State of North Carolina, this 22nd day of November, 2021.

KATIE E NEUMANN NOTARY PUBLIC ORANGE COUNTY, NC

Signature of Notary

DECLARATION OF SAM SILVAINE

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	No. 1:19-cv-00272-LCB-LPA **DECLARATION OF SAM SILVAINE**

1. I am a plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am a 33-year-old transgender man.

3. I was designated female at birth but have a male affirmed sex. I live all aspects of my life in accordance with my gender identity.

4. I am a Licensed Clinical Mental Health Counselor and own my own counseling practice.

5. I previously worked as a North Carolina state employee at North Carolina State University ("NCSU"), where I was a post-master's counseling fellow. I was enrolled in the 80/20 NCSHP for plan years 2016, 2017, and 2018.

6. While covered by the NCSHP, I paid the same amount for coverage as other State employees on the 80/20 plan.

7. While I was working at NCSU, I lived with significant distress caused by gender dysphoria. This included distress and anxiety about how people treated me with regard to my gender, and discomfort with my physical appearance and with being seen as a woman. I felt this distress every day, almost constantly, and knew that I needed something to be different.

8. As part of my prescribed treatment for gender dysphoria, in April 2017, I began hormone therapy.

9. After struggling for so long with the feeling that my body did not match my gender identity, it was a relief to finally see myself come into alignment, at least in some regards, with my gender identity. Specifically, hormone therapy masculinized my voice, some of my secondary sex characteristics, and my physical appearance.

10. Unfortunately, hormone treatment was not sufficient to alleviate my gender dysphoria. I still felt significant, daily distress related to my female-presenting chest. As my body became more masculine as a result of hormone therapy and in greater alignment with my gender identity, my typically female chest began to be even more noticeable to me. The marked incongruence increased my gender dysphoria.

11. Not only did I feel that this aspect of my body was out of alignment with my gender identity, but it caused a risk to my safety to have a female-presenting chest when I otherwise presented as male.

12. While I used a binder to compress my chest, binding caused me physical discomfort and restricted my physical activities. I love the outdoors and believe that time in nature is essential to my mental and physical well-being. Binding made it difficult for me to spend time in nature hiking, backpacking, and climbing.

13. Eventually, in consultation with and support from my health care providers, I made the decision to seek chest surgery as part of treatment for my gender dysphoria.

14. In 2017, my NCSHP plan did not contain a categorical Exclusion for gender-confirming health care. My counseling and hormone therapy were covered. In August 2017, my surgeon and I sought preauthorization for reconstructive chest surgery.

15. The preauthorization process took until fall of 2017 and at that time, the earliest available surgery date that I could obtain was in March 2018. I accepted the March 2018 date in order to avoid an even greater delay in the treatment I required.

16. After the categorical Exclusion of gender-confirming care was reinstated on January 1, 2018, the prior authorization for my surgery was rendered invalid.

17. When I found out that my health insurance was no longer going to cover the surgery I desperately needed, I was devastated mentally and emotionally. Like other transgender North Carolina state employees who suddenly found themselves without health insurance coverage for their medically necessary health care, I was placed in a difficult position.

18. I was living with severe gender dysphoria and ultimately, I could not delay the surgery. I paid for the surgery out of pocket and underwent chest surgery on March 1, 2018. I was billed a total of $7,100 for the surgery.

19. The surgery proved life-changing, even potentially lifesaving, for me and has significantly reduced the distress caused by my gender dysphoria. I feel that if I had not received this surgery and brought my body into alignment with my gender identity, I would be chronically suicidal.

20. I have not been reimbursed by Defendants for my surgery costs or other out-of-pocket costs I incurred due to the Exclusion of gender-confirming health care in the 2018 plan.

* * *

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: 11/22/2021

Sam Silvaine

Subscribed and sworn before me, a Notary Public in and for the Wake County, State of North Carolina, this 22 day of November, 2021.

Commission expiry: AUG 23 2026

Sudar Nepal
Signature of Notary

CERTIFICATE OF SERVICE

I certify that the foregoing document was filed electronically with the Clerk of Court using the CM/ECF system which will send notification of such filing to all registered users.

Dated: November 30, 2021

/s/ Amy E. Richardson

Amy E. Richardson
N.C. State Bar No. 28768
HARRIS, WILTSHIRE & GRANNIS LLP
1033 Wade Avenue, Suite 100
Raleigh, NC 27605-1155
Telephone: 919-429-7386
Facsimile: 202-730-1301
arichardson@hwglaw.com

Counsel for Plaintiffs

DECLARATION OF SHELLEY K. BUNTING

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*, *Plaintiffs*, v. DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, *et al.*, *Defendants*.	No. 1:19-cv-00272-LCB-LPA **DECLARATION OF SHELLEY K. BUNTING**

Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

1. I am the parent and next friend of C.B., a plaintiff in the above-captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am the mother of C.B., a 16-year-old boy. I have also been a nurse practitioner for over 20 years.

3. C.B. is a junior in high school. Like many teenage boys, he likes hanging out with his friends, swimming, cars, and playing video games.

4. C.B. is transgender, which means he was designated "female" at birth but has a male gender identity.

5. Ever since he was a young child, C.B. would reject stereotypically female clothing and would dress in a more masculine manner. There were times he would refuse to leave the house if the outfit I had picked out for him was too feminine or would be considered "girl's clothes."

6. In late 2016, he began wearing a short, typically masculine haircut.

7. Though C.B. always got along with people and has many friends, he exhibited high levels of anxiety and depressive behaviors that concerned me as his mother. His father and I later came to understand that these behaviors were was associated with C.B.'s untreated gender dysphoria.

8. In January 2017, C.B., who was then 11 years old, called me into his room. He had something to tell me, and I could tell it was very hard for him to say it. Finally, he said, "Mama, I don't think I am supposed to be a girl." I hugged him, reassured him, and told him we would figure this out together.

9. We spent the next several months gathering information and learning what it means to be transgender.

10. Soon after C.B. shared with me who he was and how he felt, C.B., his father Michael D. Bunting, Jr., and I all met various times with a therapist in early 2017. After consultation with the therapist, C.B. asked to be placed on treatment to delay female puberty.

11. In April of 2017, C.B., Mr. Bunting, and I sought an appointment with the Duke Child and Adolescent Gender Care Clinic ("Duke"), which was ultimately scheduled for August 2017.

12. During the summer of 2017, C.B. socially transitioned to living as his true self, informing friends and family of his male gender identity, wearing more masculine clothes, and living openly as the boy he is. However, as his chest began to develop

during the summer, I recall C.B. experiencing additional anxiety. C.B. was mortified by his breast buds and we spent all summer putting band aids over them so they were not visible through his swim shirts.

13. As a result of the distress associated with his birth-designated sex, C.B. was diagnosed with gender dysphoria. In August 2017, C.B. began obtaining care from medical and mental health professionals and was prescribed puberty-delaying treatment, in the form of an implant, as part of his treatment for gender dysphoria.

14. Following the beginning of C.B.'s treatment, we noticed that the anxiety he had been experiencing diminished and that he became a more happy, outgoing, and personable teenage boy. As parent, it was such a relief to see my son begin to be truly comfortable in his own skin.

15. In fact, C.B. is treated and known as a boy at school and in all other aspects of his life. He legally changed his name to his current more typically male name in the Spring of 2018, and his passport and driver's license both reflect that he is male.

16. Because Mr. Bunting enrolled in the NCSHP as a North Carolina state employee and remains enrolled and continues to receive health care benefits as a retiree, C.B. is also enrolled in the NCSHP, as a dependent. Our family contributes a premium each month to the plan. We pay the same amount for family coverage as others, even though we receive inferior coverage because of the exclusion for gender-affirming care.

17. When C.B. came out to us in 2017, the NCSHP did not contain an exclusion for coverage of gender-confirming health care. As a result, we were fortunate

enough to have coverage for C.B.'s treatment for his gender dysphoria when we first started this journey in 2017.

18. Without coverage in 2017, it would have been much more difficult, if not impossible, for us to pay for the medical care C.B. needed at the time. Without such treatment, C.B. would have undergone a puberty inconsistent with who he is and which would have been source of a lot of anxiety and stress for him. I cannot imagine how we would have handled that as a family and how worried we would have been about C.B.'s wellbeing.

19. C.B.'s puberty-delaying implant was only meant to last 12 to 18 months. Accordingly, C.B. needed the implant to be removed and replaced in early 2019.

20. However, in mid-2018, I learned of the reinstitution of the Exclusion of coverage for gender-confirming care within the NCSHP.

21. Worried that we could not afford out-of-pocket the puberty-delaying treatment that C.B. needed, Mr. Bunting and I communicated with the NCSHP Board of Trustees, urging them to once again eliminate the Exclusion of gender-confirming health care within the NCSHP, with no success.

22. I personally testified at the NCSHP Board of Trustees meeting on October 22, 2018 and provided written testimony for the meeting on December 10, 2018.

23. Notwithstanding our pleas, the NCSHP Board of Trustees decided to keep the Exclusion of coverage for gender-confirming care in the NCSHP.

24. Figuring out how we would pay for C.B.'s gender-confirming care caused a great deal of stress and strain within our family. As parents, we want to make sure that our children get access to whatever health care they need. However, we did not have the resources to pay for a puberty-delaying implant out of pocket.

25. As we considered how we would pay for C.B.'s gender-confirming care, we contemplated several options including having my husband retire and find a new job outside of the state system, increasing my hours at work to full time, or trying to purchase a separate medical policy for my son through the Affordable Care Act Marketplace. None of these options were ideal since my husband was not ready to leave his job, I love the balance I have between family and professional life, and another policy would cost us several hundreds of dollars per month if C.B. qualified.

26. Ultimately, we needed to avail ourselves of more than one of the above options to pay for C.B.'s care.

27. In mid-December 2018, following the lack of action by the NCSHP Board of Trustees at their December 2018 meeting to eliminate the Exclusion, Mr. Bunting and I decided to purchase an additional health insurance plan that would cover puberty-delaying treatment for C.B. Through the federally-run ACA health care exchange, we purchased an additional insurance plan for C.B. from Blue Cross Blue Shield of North Carolina. A true and correct copy of the Certification of Health Insurance Coverage for this plan is attached as Exhibit A.

28. Though C.B. and Mr. Bunting remained enrolled in the NCSHP and will continue to do so, purchasing additional coverage for C.B. was necessary for my family to be able to afford C.B.'s gender-confirming care. As a result, Mr. Bunting and I had to pay an additional monthly premium of $199.57 as well as a $6,750.00 deductible for C.B., separate and apart from C.B.'s existing coverage under the NCSHP.

29. In early 2019, C.B. began obtaining puberty-delaying treatment via injection, rather than a longer-lasting implant, because that was the only puberty-delaying treatment on the formulary of the additional health insurance we purchased to supplement the coverage under the NCSHP.

30. In March 2019, C.B. was also prescribed testosterone as part of his treatment for gender dysphoria. Due to the Exclusion, the NCSHP has not covered any of this care.

31. On March 21, 2019, CVS, which administers the prescription benefits under the NCSHP, issued a Notice of Determination denying prior authorization for coverage of C.B's Testosterone Cypionate IM Injection prescription. The Notice of Determination explained that C.B. did not meet the requirements of the NCSHP. Per the Notice of Determination, the prescription would have been covered for "primary or hypogonadotropic hypogonadism," among other reasons. A true and correct copy of the Notice of Determination is attached as Exhibit B.

32. On March 25, 2019, January 17, 2020, and March 23, 2020, CVS issued additional Notices of Determination denying coverage for C.B.'s Testosterone Cypionate

IM Injection because he did not meet the requirements of the plan and the plan would cover the prescription if C.B. had "primary or hypogonadotropic hypogonadism." True and correct copies of theses Notices of Determination is attached as Exhibit C, Exhibit D, and Exhibit E, respectively.

33. Aside from having to purchase the additional coverage for C.B., the lack of coverage under the NCSHP due to the discriminatory Exclusion forced our family to make difficult decisions. Given the high deductible of $6,750.00 that was part of the additional coverage, we still needed to come up with ways in which we could increase our income in order to pay for C.B.'s necessary care. This was a significant contributing factor to Mr. Bunting's decisions to retire from his job at UNC, which allowed him to obtain a new job and increase the family's income.

34. Mr. Bunting and C.B. remain enrolled in the NCSHP as a retiree and his dependent, respectively.

35. C.B. continues to receive masculinizing hormone therapy as part of his gender-confirming care. While the family no longer purchases separate ACA coverage, C.B.'s hormone therapy is not covered by the NCSHP and we must pay for that care out-of-pocket.

36. The Exclusion discriminates against and stigmatizes C.B. as a transgender person which has impacted our family financially and emotionally, causing us to live a life of ongoing stress, anxiety, and uncertainty.

37. No child should be denied medically necessary care because of who he is. Being discriminated against does not feel good. Yet, that is what the NCSHP has done to my son and our family by refusing to cover his medically necessary health care because he is transgender. It makes me mad and sad at the same time to know that our state refuses to pay for medically necessary health care for its own state employees and their families.

I declare under the penalty of perjury that the foregoing is true and correct.

DATED: November 24, 2021

Shelley K. Bunting

Shelley K. Bunting

Subscribed and sworn before me, a Notary Public in and for the Chatham County,

State of NC, this 24 day of November, 2021.

MARGARET E ASHNESS NOTARY PUBLIC CHATHAM COUNTY, NC

Margaret E Ashness

Signature of Notary

5/12/2020

Exhibit A

Declaration of Shelley K. Bunting
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association.

CERTIFICATION OF HEALTH INSURANCE COVERAGE

12/31/2019

Subscriber ID: [redacted]

IMPORTANT - KEEP THIS CERTIFICATE: This certificate confirms your dates of health care coverage. Our records indicate your coverage was terminated as of the DATE COVERAGE ENDS shown below due to the subscriber requesting to be terminated from the policy. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

MEMBER NAME	DATE COVERAGE BEGAN*	DATE COVERAGE ENDED
[redacted] C.B.	01/01/19	12/31/19

* "Date Coverage Began" only reflects the start date of your most recent coverage. You may have had other Blue Cross and Blue Shield of North Carolina coverage that is not reflected in this certificate.

For questions about this form, please call Customer Service at 1-888-206-4697, 8 a.m. to 7 p.m., Monday through Friday, EST. We hope to have the opportunity to provide you and your family with your health plan needs again in the future.

STATEMENT OF HIPAA PORTABILITY RIGHTS

Preexisting condition exclusions: Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan: Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor: Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged for a similarly situated individual.

Right to individual health coverage: Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

Exhibit B

Declaration of Shelley K. Bunting
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA

CVS caremark

North Carolina State Health Plan for Teachers and State Employees
A Division of the Department of State Treasurer

Notice of Determination

Date: 03/21/2019

C.B.
[redacted]
CHAPEL HILL, NC [redacted]

Plan Member Name: C.B.
Plan Member ID: *******[redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: [redacted]
Prescriber Phone: 1-9196848225
Prescriber Fax: 1-9198625782

Dear C.B.:

CVS Caremark ® received a request from your provider for coverage of Testosterone Cypionate IM Injection. The request was denied because:

You do not meet the requirements of your plan. Your plan Testosterone Products criteria covers this drug when you meet one of these conditions:
- You have primary or hypogonadotropic hypogonadism
- For testosterone enanthate injection (generic Delatestryl), you are a postmenopausal patient with metastatic breast cancer, surgery is not possible, and other drugs for your cancer did not work for you
- For testosterone enanthate injection (generic Delatestryl), you are a premenopausal patient with breast cancer, have a hormone-responsive tumor, and had your ovaries removed
- Testosterone enanthate injection (generic Delatestryl) or Testopel is being prescribed for delayed puberty

Your request has been denied based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at 888-321-3124.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org.**

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

91-40230B 110818 TDD/TTY: 1-800-863-5488

Exhibit C

Declaration of Shelley K. Bunting
Kadel v. Folwell, No. 1:19-cv-00272-LCB-LPA

CVS caremark

State Health Plan

Notice of Determination

Date: 03/25/2019

C.B.
[redacted]
CHAPEL HILL, NC [redacted]

Plan Member Name: C.B.
Plan Member ID: ******* [redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: [redacted]
Prescriber Phone: 1-919-862-1200
Prescriber Fax: 1-919-862-5782

Dear C.B.:

CVS Caremark ® received a request from your provider for coverage of Testosterone Cypionate IM Injection. The request was denied because:

You do not meet the requirements of your plan. Your plan covers this drug when you have primary or hypogonadotropic hypogonadism. Your request has been denied based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at 888-321-3124.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org**.

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

If your situation is urgent as defined by law, you may ask for an expedited appeal. Important information about your appeal rights and directions about how to ask for an appeal are provided with this letter.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark .
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-40230B 110818 TDD/TTY: 1-800-863-5488

If your provider would like to discuss this decision with a clinical reviewer at CVS Caremark , your provider can call CVS Caremark , and we will make arrangements for the conversation.

If you have questions, please call Customer Care at 888-321-3124.

Sincerely,

CVS Caremark

Enclosures

cc: Dr. [redacted]

PA# North Carolina State Health Plan 0274 Non-Grandfathered 19-038180875 SB
Plan-approved Criteria: Testosterone Products
Claim Amount (if available): 0.0
Service Date: 3/25/2019 3:28:05 PM

If your provider included diagnosis or treatment codes with your claim for Testosterone Cypionate IM Injection to CVS Caremark , that information is listed here:
ICD diagnosis code: E34.9
Associated diagnosis: Endocrine disorder, unspecified
CPT treatment code:
Associated treatment:
You may wish to contact your provider for more information about these codes.

Important Information About Your Appeal Rights

What if I need help understanding this denial? You may contact CVS Caremark by calling **1-800-294-5979** if you need assistance understanding this notice or our decision to deny you a service or coverage.

What options does my provider have? If there is relevant information that has not been previously submitted, the treating physician may request a Provider Courtesy Review (PCR) by calling **1-800-446-8053 extension 52961** or by sending a written request within 180 days to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Provider Courtesy Review
PO Box 30055
Durham, NC 27702

What if I don't agree with this decision? You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702

A member appeal form is available on the Web at **www.BCBSNC.com**.

What if my situation is urgent? If your situation meets the legal definition of urgency, the review of your claim will be conducted within 72 hours, or earlier if required by law. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your situation is urgent, you or your physician may request an expedited appeal by contacting Blue Cross and Blue Shield of North Carolina (Blue Cross NC) via mail or fax at the address below. In addition, you may have the ability to seek an expedited external review of your adverse benefit determination. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID Card.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level 1
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark .
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-40230B 110818 TDD/TTY: 1-800-863-5488

Who may file an appeal? You or someone whom you name to act for you (your authorized representative) may file an appeal. A member consent form is attached for your convenience and is also available online at **www.BCBSNC.com**.

Can I provide additional information about my appeal? Yes. As part of the appeal process, you have the right to submit supporting materials in advance of a decision being made on your appeal.

What happens next? If you appeal, BLUE CROSS NC will review the decision and provide you a written determination within 30 calendar days. If the adverse benefit determination is overturned, BLUE CROSS NC will provide coverage or payment for your health care item or service. If the adverse benefit determination is upheld, you may have additional appeal rights.

How do I file a request for external review? You may be eligible for an external review process. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID card.

What other remedies do I have? Depending on your plan, you may also have the right to bring action under section 502(a) of ERISA. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Can I request copies of information relevant to my adverse benefit determination? Yes. You may request and receive, at no cost to you, reasonable access to and copies of all documents, records and other information relevant to your claim by writing to:

Blue Cross and Blue Shield of North Carolina
Healthcare Management & Operations
P. O. Box 2291
Durham, NC 27702

This information may also include the following:

- Any internal rules, guidelines, protocols, or other criteria used to make this decision, including any clinical review criteria indicated above (please include the referenced medical policy from page 1 of this notice with your request); and/or
- If the decision is based on medical necessity, experimental treatment or another similar exclusion, an explanation of the scientific or clinical judgment for the determination, applied to your medical circumstances.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**. You may also receive assistance with appeals from Smart

NC by contacting:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
1-855-408-1212 (toll-free)

External Review
North Carolina law provides for review of *adverse benefit determinations* by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. *BLUE CROSS NC* will notify you of your right to request an external review each time you receive:

- An *adverse benefit determination*, or
- An appeal decision upholding an *adverse benefit determination* or
- A second-level *appeal* decision upholding an *adverse benefit determination*.

You or someone whom you have authorized to represent you may request an external review.

In order for your request to be eligible for an external review, the NCDOI must determine the following:

- Your request is about a *medical necessity* determination that resulted in an *adverse benefit determination (i.e., a noncertification)*;
- You had coverage with *BLUE CROSS NC* when the *adverse benefit determination* was issued;
- The service for which the *adverse benefit determination* was issued appears to be a *covered service*; and
- You have exhausted *BLUE CROSS NC's* internal *appeal* review process as described below.

For a standard external review, you will have exhausted the internal *appeal* review process if you have:

- Completed *BLUE CROSS NC's* first- and second-level *appeal* review and received a written second-level determination from *BLUE CROSS NC*, or
- Filed a second-level *appeal* and have not requested or agreed to a delay in the second-level *appeal* process, but have not received *BLUE CROSS NC's* written decision within 60 days from the date that you can demonstrate that an appeal was filed with BLUE CROSS NC, or
- received written notification that *BLUE CROSS NC* has agreed to waive the requirement to exhaust the internal *appeal* and/or second-level *appeal* process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited

review.

Standard External Review
For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective *adverse benefit determination* (an *adverse benefit determination* that occurs after you have already received the services in question), the 60-day time limit for receiving *BLUE CROSS NC's* second-level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second-level determination from *BLUE CROSS NC*.

Expedited External Review
An expedited external review may be available if the time required to complete either an expedited internal first- or second-level appeal review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- An *adverse benefit determination* from *BLUE CROSS NC* and have filed a request with *BLUE CROSS NC* for an expedited first-level appeal; or
- A first-level appeal decision upholding an *adverse benefit determination* and have filed a request with *BLUE CROSS NC* for an expedited second-level *appeal* review; or
- A second-level *appeal* review decision from *BLUE CROSS NC*.

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first-level appeal or second-level appeal decision concerning an adverse benefit determination of the admission, availability of care, continued stay or emergency health care services.

If your request is not accepted for expedited review, the NCDOI may (1) accept the case for standard external review if you have exhausted the internal appeal review process; or (2) require the completion of the internal appeal review process and another request for an external review. An expedited external review is not available for retrospective adverse benefit determinations.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review. For further information about external review or to request an external review, contact the NCDOI at:

(Mail)
By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll-Free Telephone: **1-855-408-1212**
www.ncdoi.com/smart

(In person)
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/Smart
Toll-Free Telephone: **1-855-408-1212**

The Healthcare Review Program provides consumer counseling on utilization review and appeal issues. Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your provider of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from BLUE CROSS NC upholding an adverse benefit determination (generally the notice of a second-level appeal review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that BLUE CROSS NC has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial adverse benefit determination to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BLUE CROSS NC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BLUE CROSS NC shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the adverse benefit determination, appeal decision or the second-level appeal review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to BLUE CROSS NC at the same time and by the same means of communication (e.g., you must fax the information to BLUE CROSS NC if you faxed it to the IRO). When sending additional information to BLUE CROSS NC, send it to:

(Mail)
Blue Cross/Blue Shield of North Carolina
Appeals Department
PO Box 30055
Durham, NC 27702

Questions? Do you need help in a different language or format? If you do not speak English or have special needs, oral interpretation and alternate formats of this notice are available, as is other assistance, by contacting us at the number on your State Health Plan ID card.

Spanish:
Si usted necesita asistencia o necesita hablar con alguien en Español, por favor llame al número gratuito de Servicio al Cliente ubicado en su tarjeta de identificación de beneficios.

Chinese (simplified):
如果您需要帮助，或需要同中国人讲话，请拨打您的福利卡上面的客户服务免费电话号码。

Tagalog:
Kung kailangan ninyo ng tulong o kailangan ninyong makipag-usap sa isang tao sa Tagalog, mangyari lamang na tumawag nang walang-bayad sa Serbisyo sa Kostumer sa numero na nakasulat sa inyong ID kard ng benepisyo.

Navajo:
Shíka at'ohwol ei doodaii' dinék'ehgo łą bi'chį haadeedziih nínízinígo, t'áá shǫǫdí, t'áá jíík'e ya ndaalníshí, ni naaltsoos bikáa'gi bi'chį hodiilniih.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark .
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-40230B 110818 TDD/TTY: 1-800-863-5488

Notice of Nondiscrimination

Federal civil rights laws prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, age, disability, or sex. The laws apply to health programs and activities that receive funding from the Federal government, are administered by a Federal agency or are offered on a public Health Insurance Marketplace. Health plans that are subject to the laws include Medicare Part D plans, Medicaid plans, health plans offered by issuers on Health Insurance Marketplaces, and certain employee health benefit plans. If you have questions about whether these Federal civil rights laws apply to your plan, please contact your health plan at the number in your benefit plan materials.

If your health plan is subject to these Federal civil rights laws, it complies with the laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

- Provides appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us, such as:
  - Auxiliary aids and services
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe these services have not been appropriately provided to you or you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email with your health plan's Civil Rights Coordinator.

You may also contact Customer Care and we will direct your grievance to your health plan's Civil Rights Coordinator:

Nondiscrimination Grievance Coordinator
PO BOX 6590, Lee's Summit, MO 64064-6590
Phone: 1-866-526-4075
TTY: 1-800-863-5488
Fax: 1-855-245-2135
Email: nondiscrimination@cvscaremark.com

If you need additional help filing a grievance, your health plan's Civil Rights Coordinator is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

106-39432A-092316

Exhibit D

CVS caremark

State Health Plan

Notice of Determination

Date: 01/17/2020

C.B.
[redacted]
CHAPEL HILL, NC [redacted]

Plan Member Name: C.B. [redacted]
Plan Member ID: ******* [redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: [redacted]
Prescriber Phone: 1-9196848225
Prescriber Fax: 1-9198625372

Dear C.B. [redacted]:

CVS Caremark ® received a request from your provider for coverage of Testosterone Cypionate IM Injection. The request was denied because:

You do not meet the requirements of your plan. Your Testosterone Products plan covers this drug when you meet one of these conditions:
- You have primary or hypogonadotropic hypogonadism
Your request has been denied based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at **888-321-3124**.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org**.

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

If your situation is urgent as defined by law, you may ask for an expedited appeal. Important information about your appeal rights and directions about how to ask for an

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Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-40230B 081319 TDD/TTY: 1-800-863-5488

appeal are provided with this letter.

If your provider would like to discuss this decision with a clinical reviewer at CVS Caremark , your provider can call CVS Caremark , and we will make arrangements for the conversation.

If you have questions, please call Customer Care at **888-321-3124**.

Sincerely,

CVS Caremark

Enclosures

cc: Dr. [redacted]

PA# North Carolina State Health Plan 0274 Non-Grandfathered 20-043207569 MN
Plan-approved Criteria: Testosterone Products
Claim Amount (if available):
Service Date: 1/17/2020 12:22:09 PM

If your provider included diagnosis or treatment codes with your claim for Testosterone Cypionate IM Injection to CVS Caremark , that information is listed here:
ICD diagnosis code: F64.0
Associated diagnosis: Transsexualism
CPT treatment code:
Associated treatment:
You may wish to contact your provider for more information about these codes.

Important Information About Your Appeal Rights

What if I need help understanding this denial? You may contact CVS Caremark by calling **1-800-294-5979** if you need assistance understanding this notice or our decision to deny you a service or coverage.

What options does my provider have? If there is relevant information that has not been previously submitted, the treating physician may request a Provider Courtesy Review (PCR) by calling **1-800-446-8053** and ask for Pharmacy Provider Courtesy Reviews or by calling **(919) 765-2961**. You may also send a written request within 180 days to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Provider Courtesy Review
PO Box 30055
Durham, NC 27702

What if I don't agree with this decision? You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702

A member appeal form is available on the Web at **www.BCBSNC.com**.

What if my situation is urgent? If your situation meets the legal definition of urgency, the review of your claim will be conducted within 72 hours, or earlier if required by law. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your situation is urgent, you or your physician may request an expedited appeal by contacting Blue Cross and Blue Shield of North Carolina (Blue Cross NC) via mail or fax at the address below. In addition, you may have the ability to seek an expedited external review of your adverse benefit determination. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID Card.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level 1
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

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Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-40230B 081319 TDD/TTY: 1-800-863-5488

Who may file an appeal? You or someone whom you name to act for you (your authorized representative) may file an appeal. A member consent form is attached for your convenience and is also available online at **www.BCBSNC.com**.

Can I provide additional information about my appeal? Yes. As part of the appeal process, you have the right to submit supporting materials in advance of a decision being made on your appeal.

What happens next? If you appeal, BLUE CROSS NC will review the decision and provide you a written determination within 30 calendar days. If the adverse benefit determination is overturned, BLUE CROSS NC will provide coverage or payment for your health care item or service. If the adverse benefit determination is upheld, you may have additional appeal rights.

How do I file a request for external review? You may be eligible for an external review process. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID card.

What other remedies do I have? Depending on your plan, you may also have the right to bring action under section 502(a) of ERISA. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Can I request copies of information relevant to my adverse benefit determination? Yes. You may request and receive, at no cost to you, reasonable access to and copies of all documents, records and other information relevant to your claim by writing to:

Blue Cross and Blue Shield of North Carolina
Healthcare Management & Operations
P. O. Box 2291
Durham, NC 27702

This information may also include the following:

- Any internal rules, guidelines, protocols, or other criteria used to make this decision, including any clinical review criteria indicated above (please include the referenced medical policy from page 1 of this notice with your request); and/or
- If the decision is based on medical necessity, experimental treatment or another similar exclusion, an explanation of the scientific or clinical judgment for the determination, applied to your medical circumstances.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**.

91-40230B 081319 TDD/TTY: 1-800-863-5488

You may also receive assistance with appeals from Smart NC by contacting:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201**1-855-408-1212** (toll-free)

External Review
North Carolina law provides for review of *adverse benefit determinations* by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. *BLUE CROSS NC* will notify you of your right to request an external review each time you receive:

- An *adverse benefit determination*, or
- An appeal decision upholding an *adverse benefit determination* or
- A second-level *appeal* decision upholding an *adverse benefit determination.*

You or someone whom you have authorized to represent you may request an external review.

In order for your request to be eligible for an external review, the NCDOI must determine the following:

- Your request is about a *medical necessity* determination that resulted in an *adverse benefit determination (i.e., a noncertification)*;
- You had coverage with *BLUE CROSS NC* when the *adverse benefit determination* was issued;
- The service for which the *adverse benefit determination* was issued appears to be a *covered service*; and
- You have exhausted *BLUE CROSS NC's* internal *appeal* review process as described below.

For a standard external review, you will have exhausted the internal *appeal* review process if you have:

- Completed *BLUE CROSS NC's* first- and second-level *appeal* review and received a written second-level determination from *BLUE CROSS NC*, or
- Filed a second-level *appeal* and have not requested or agreed to a delay in the second-level *appeal* process, but have not received *BLUE CROSS NC's* written decision within 60 days from the date that you can demonstrate that an appeal was filed with BLUE CROSS NC, or
- received written notification that *BLUE CROSS NC* has agreed to waive the requirement to exhaust the internal *appeal* and/or second-level *appeal* process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

Standard External Review
For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective *adverse benefit determination* (an *adverse benefit determination* that occurs after you have already received the services in question), the 60-day time limit for receiving *BLUE CROSS NC's* second-level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second-level determination from *BLUE CROSS NC.*

Expedited External Review
An expedited external review may be available if the time required to complete either an expedited internal first- or second-level appeal review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- An *adverse benefit determination* from *BLUE CROSS NC* and have filed a request with *BLUE CROSS NC* for an expedited first-level appeal; or
- A first-level appeal decision upholding an *adverse benefit determination* and have filed a request with *BLUE CROSS NC* for an expedited second-level *appeal* review; or
- A second-level *appeal* review decision from *BLUE CROSS NC.*

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first-level appeal or second-level appeal decision concerning an adverse benefit determination of the admission, availability of care, continued stay or emergency health care services.

If your request is not accepted for expedited review, the NCDOI may (1) accept the case for standard external review if you have exhausted the internal appeal review process; or (2) require the completion of the internal appeal review process and another request for an external review. An expedited external review is not available for retrospective adverse benefit determinations.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review. For further information about external review or to request an external review, contact the NCDOI at:

Questions? Do you need help in a different language or format? If you do not speak English or have special needs, oral interpretation and alternate formats of this notice are available, as is other assistance, by contacting us at the number on your State Health Plan ID card.

Spanish:
Si usted necesita asistencia o necesita hablar con alguien en Español, por favor llame al número gratuito de Servicio al Cliente ubicado en su tarjeta de identificación de beneficios.

Chinese (simplified):
如果您需要帮助，或需要同中国人讲话，请拨打您的福利卡上面的客户服务免费电话号码。

Tagalog:
Kung kailangan ninyo ng tulong o kailangan ninyong makipag-usap sa isang tao sa Tagalog, mangyari lamang na tumawag nang walang-bayad sa Serbisyo sa Kostumer sa numero na nakasulat sa inyong ID kard ng benepisyo.

Navajo:
Shíka at'ohwol ei doodaii' dinék'ehgo łą bi'chį haadeedziih nínízinígo, t'áá shǫǫdí, t'áá jíík'e ya ndaalníshí, ni naaltsoos bikáa'gi bi'chį hodiilniih.

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91-40230B 081319 TDD/TTY: 1-800-863-5488

Exhibit E

CVS caremark

North Carolina State Health Plan

Notice of Determination

Date: 03/23/2020

C.B.
[redacted]
CHAPEL HILL, NC [redacted]

Plan Member Name: C.B.
Plan Member ID: *******[redacted]
Plan Name: North Carolina State Health Plan 0274 Non-Grandfathered

Prescriber Name: [redacted]
Prescriber Phone: 1-9199543993
Prescriber Fax: 1-9198625782

Dear C.B.

CVS Caremark ® received a request from your provider for coverage of Testosterone Cypionate 200MG/ML IM SOLN. The request was denied because:

You do not meet the requirements of your plan. Your plan approved Testosterone Products criteria covers this drug when you meet one of these conditions:
- You have primary or hypogonadotropic hypogonadism
- For testosterone enanthate injection (generic Delatestryl), you are a postmenopausal patient with metastatic breast cancer, surgery is not possible, and other drugs for your cancer did not work for you
- For testosterone enanthate injection (generic Delatestryl), you are a premenopausal patient with breast cancer, have a hormone-responsive tumor, and had your ovaries removed
- Testosterone enanthate injection (generic Delatestryl) or Testopel is being prescribed for delayed puberty

Your request has been denied based on the information we have.

You can ask for a free copy of the actual benefit provision, guideline, protocol or other similar criterion used to make the decision and any other information related to this decision by calling Customer Care at **888-321-3124**.

For more information regarding your prescription benefit, please refer to your Benefit Booklet available on the Plan's website at **www.shpnc.org**.

You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter. Please mail or fax your appeal to:

91-49230B 081319 TDD/TTY: 1-800-863-5488

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

If your situation is urgent as defined by law, you may ask for an expedited appeal. Important information about your appeal rights and directions about how to ask for an appeal are provided with this letter.

If your provider would like to discuss this decision with a clinical reviewer at CVS Caremark , your provider can call CVS Caremark , and we will make arrangements for the conversation.

If you have questions, please call Customer Care at **888-321-3124**.

Sincerely,

CVS Caremark

Enclosures

cc: Dr. [redacted]

PA# North Carolina State Health Plan 0274 Non-Grandfathered 20-044413290 JR
Plan-approved Criteria: Testosterone Products
Claim Amount (if available):
Service Date: 3/23/2020 3:21:05 PM

If your provider included diagnosis or treatment codes with your claim for Testosterone Cypionate 200MG/ML IM SOLN to CVS Caremark , that information is listed here:
ICD diagnosis code: F64.0
Associated diagnosis: Transsexualism
CPT treatment code:
Associated treatment:
You may wish to contact your provider for more information about these codes.

Important Information About Your Appeal Rights

What if I need help understanding this denial? You may contact CVS Caremark by calling **1-800-294-5979** if you need assistance understanding this notice or our decision to deny you a service or coverage.

What options does my provider have? If there is relevant information that has not been previously submitted, the treating physician may request a Provider Courtesy Review (PCR) by calling **1-800-446-8053** and ask for Pharmacy Provider Courtesy Reviews or by calling **(919) 765-2961**. You may also send a written request within 180 days to:

Blue Cross/Blue Shield of North Carolina
Appeals Department / Provider Courtesy Review
PO Box 30055
Durham, NC 27702

What if I don't agree with this decision? You may request an appeal by sending a written request to the address below. To be eligible for an appeal, your request must be in writing and received within 180 days of the date of this letter.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level I
PO Box 30055
Durham, NC 27702

A member appeal form is available on the Web at **www.BCBSNC.com**.

What if my situation is urgent? If your situation meets the legal definition of urgency, the review of your claim will be conducted within 72 hours, or earlier if required by law. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your situation is urgent, you or your physician may request an expedited appeal by contacting Blue Cross and Blue Shield of North Carolina (Blue Cross NC) via mail or fax at the address below. In addition, you may have the ability to seek an expedited external review of your adverse benefit determination. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID Card.

Blue Cross/Blue Shield of North Carolina
Appeals Department / Level 1
PO Box 30055
Durham, NC 27702
Fax: 1-919-765-2322

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91-40230B 081319 TDD/TTY: 1-800-863-5488

Who may file an appeal? You or someone whom you name to act for you (your authorized representative) may file an appeal. A member consent form is attached for your convenience and is also available online at **www.BCBSNC.com**.

Can I provide additional information about my appeal? Yes. As part of the appeal process, you have the right to submit supporting materials in advance of a decision being made on your appeal.

What happens next? If you appeal, BLUE CROSS NC will review the decision and provide you a written determination within 30 calendar days. If the adverse benefit determination is overturned, BLUE CROSS NC will provide coverage or payment for your health care item or service. If the adverse benefit determination is upheld, you may have additional appeal rights.

How do I file a request for external review? You may be eligible for an external review process. To determine whether an external review process is available to you, please consult your benefit booklet or call BLUE CROSS NC customer service on the back of your ID card.

What other remedies do I have? Depending on your plan, you may also have the right to bring action under section 502(a) of ERISA. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Can I request copies of information relevant to my adverse benefit determination? Yes. You may request and receive, at no cost to you, reasonable access to and copies of all documents, records and other information relevant to your claim by writing to:

Blue Cross and Blue Shield of North Carolina
Healthcare Management & Operations
P. O. Box 2291
Durham, NC 27702

This information may also include the following:

- Any internal rules, guidelines, protocols, or other criteria used to make this decision, including any clinical review criteria indicated above (please include the referenced medical policy from page 1 of this notice with your request); and/or
- If the decision is based on medical necessity, experimental treatment or another similar exclusion, an explanation of the scientific or clinical judgment for the determination, applied to your medical circumstances.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at **1-866-444-EBSA (3272)**.

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91-40230B 081319 TDD/TTY: 1-800-863-5488

You may also receive assistance with appeals from Smart NC by contacting:

North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201**1-855-408-1212** (toll-free)

External Review
North Carolina law provides for review of *adverse benefit determinations* by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. *BLUE CROSS NC* will notify you of your right to request an external review each time you receive:

- An *adverse benefit determination*, or
- An appeal decision upholding an *adverse benefit determination* or
- A second-level *appeal* decision upholding an *adverse benefit determination*.

You or someone whom you have authorized to represent you may request an external review.

In order for your request to be eligible for an external review, the NCDOI must determine the following:

- Your request is about a *medical necessity* determination that resulted in an *adverse benefit determination (i.e., a noncertification)*;
- You had coverage with *BLUE CROSS NC* when the *adverse benefit determination* was issued;
- The service for which the *adverse benefit determination* was issued appears to be a *covered service*; and
- You have exhausted *BLUE CROSS NC's* internal *appeal* review process as described below.

For a standard external review, you will have exhausted the internal *appeal* review process if you have:

- Completed *BLUE CROSS NC's* first- and second-level *appeal* review and received a written second-level determination from *BLUE CROSS NC*, or
- Filed a second-level *appeal* and have not requested or agreed to a delay in the second-level *appeal* process, but have not received *BLUE CROSS NC's* written decision within 60 days from the date that you can demonstrate that an appeal was filed with BLUE CROSS NC, or
- received written notification that *BLUE CROSS NC* has agreed to waive the requirement to exhaust the internal *appeal* and/or second-level *appeal* process.

External reviews are performed on a standard or expedited basis, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

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91-40230B 081319 TDD/TTY: 1-800-863-5488

Standard External Review
For all requests for a standard external review, you must file your request with the NCDOI within 120 days of receiving one of the notices listed above.

If the request for an external review is related to a retrospective *adverse benefit determination* (an *adverse benefit determination* that occurs after you have already received the services in question), the 60-day time limit for receiving *BLUE CROSS NC's* second-level determination does not apply. You will not be eligible to request an external review until you have exhausted the internal appeal process and have received a written second-level determination from *BLUE CROSS NC.*

Expedited External Review
An expedited external review may be available if the time required to complete either an expedited internal first- or second-level appeal review or a standard external review would reasonably be expected to seriously jeopardize your life or health or to jeopardize your ability to regain maximum function. If you meet this requirement, you may file a request to the NCDOI for an expedited external review, after you receive:

- An *adverse benefit determination* from *BLUE CROSS NC* and have filed a request with *BLUE CROSS NC* for an expedited first-level appeal; or
- A first-level appeal decision upholding an *adverse benefit determination* and have filed a request with *BLUE CROSS NC* for an expedited second-level *appeal* review; or
- A second-level *appeal* review decision from *BLUE CROSS NC.*

In addition, prior to your discharge from an inpatient facility, you may also request an expedited external review after receiving a first-level appeal or second-level appeal decision concerning an adverse benefit determination of the admission, availability of care, continued stay or emergency health care services.

If your request is not accepted for expedited review, the NCDOI may (1) accept the case for standard external review if you have exhausted the internal appeal review process; or (2) require the completion of the internal appeal review process and another request for an external review. An expedited external review is not available for retrospective adverse benefit determinations.

When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that need to be reviewed for the purpose of reaching a decision on the external review. For further information about external review or to request an external review, contact the NCDOI at:

(Mail)
By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll-Free Telephone: **1-855-408-1212**
www.ncdoi.com/smart

(In person)
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/Smart
Toll-Free Telephone: **1-855-408-1212**

The Healthcare Review Program provides consumer counseling on utilization review and appeal issues. Within ten business days (or, for an expedited review, within three business days) of receipt of your request for an external review, the NCDOI will notify you and your provider of whether your request is complete and whether it has been accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested, additional information to the NCDOI within 150 days of the written notice from BLUE CROSS NC upholding an adverse benefit determination (generally the notice of a second-level appeal review decision), which initiated your request for an external review. If the NCDOI accepts your request, the acceptance notice will include: (i) name and contact information for the IRO assigned to your case; (ii) a copy of the information about your case that BLUE CROSS NC has provided to the NCDOI; and (iii) a notification that you may submit additional written information and supporting documentation relevant to the initial adverse benefit determination to the assigned IRO within seven days after the receipt of the notice. It is presumed that you have received written notice two days after the notice was mailed. Within seven days of BLUE CROSS NC's receipt of the acceptance notice (or, for an expedited review, within the same business day), BLUE CROSS NC shall provide the IRO and you, by the same or similar expeditious means of communication, the documents and any information considered in making the adverse benefit determination, appeal decision or the second-level appeal review decision. If you choose to provide any additional information to the IRO, you must also provide that same information to BLUE CROSS NC at the same time and by the same means of communication (e.g., you must fax the information to BLUE CROSS NC if you faxed it to the IRO). When sending additional information to BLUE CROSS NC, send it to:

(Mail)
Blue Cross/Blue Shield of North Carolina
Appeals Department
PO Box 30055
Durham, NC 27702

Questions? Do you need help in a different language or format? If you do not speak English or have special needs, oral interpretation and alternate formats of this notice are available, as is other assistance, by contacting us at the number on your State Health Plan ID card.

Spanish:
Si usted necesita asistencia o necesita hablar con alguien en Español, por favor llame al número gratuito de Servicio al Cliente ubicado en su tarjeta de identificación de beneficios.

Chinese (simplified):
如果您需要帮助，或需要同中国人讲话，请拨打您的福利卡上面的客户服务免费电话号码。

Tagalog:
Kung kailangan ninyo ng tulong o kailangan ninyong makipag-usap sa isang tao sa Tagalog, mangyari lamang na tumawag nang walang-bayad sa Serbisyo sa Kostumer sa numero na nakasulat sa inyong ID kard ng benepisyo.

Navajo:
Shíka at'ohwol ei doodaii' dinék'ehgo łą bi'chį haadeedziih nínízinígo, t'áá shǫǫdí, t'áá jíík'e ya ndaalnishí, ni naaltsoos bikáa'gi bi'chį hodiilniih.

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Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
91-40230B 081319 TDD/TTY: 1-800-863-5488