No. 23-4331

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, *et al.*,

Plaintiffs-Appellees,

v.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant-Appellant.

On Appeal from the United States District Court for the Western District of Washington, Hon. Robert J. Bryan, District Judge (No. 3:20-cv-06145-RJB)

APPELLEES' SUPPLEMENTAL EXCERPTS OF RECORD (INDEX VOLUME)

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UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiffs,	3:20-cv-06145-RJB
v.	Tacoma, Washington
BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	December 12, 2022
	Summary Judgment
	11:00 a.m.

VERBATIM REPORT OF PROCEEDINGS
BEFORE THE HONORABLE ROBERT J. BRYAN
UNITED STATES DISTRICT JUDGE

Proceedings stenographically reported and transcribed with computer-aided technology

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MORNING SESSION

DECEMBER 12, 2022

THE COURT: This is C.P. and others versus Blue Cross Blue Shield of Illinois, and comes on this morning for oral argument.

A couple of preliminary matters -- I guess I should make a record of who is present. Ms. Hamburger, Ms. Pizer and Mr. Gross are here for plaintiff. Ms. Payton and Ms. Bedard are here for the defendant.

A couple of preliminary matters. There is a motion to strike pending regarding supervised -- regarding supplemental authority filed; that motion, I think, should be granted.

There are a couple of things that should, for the record, be stricken. The first is plaintiff opened up discussion on this subject by quoting a bit of the *Kadel* case and that line on line 23 of their Docket No. 135 will be stricken as to the content of the *Kadel* case, and the defendant's response should be stricken as well. That motion is granted. You can discuss the issues you raised if you want to during argument.

I issued a draft order. That always causes some concern to lawyers. Let me explain a little bit. When a judge has the opportunity to read the pleadings before argument, you can bet that the judge has drawn some conclusions and has some ideas. Sometimes we have gone so far as to prepare an order that we have not filed when we hear oral argument, and

sometimes we do, as I did here, which is issue a discussion draft.

I guess what I am trying to say is that the discussion draft is only that. It should not be indicated as the Court's final conclusion in any way. It is a matter that we have worked on and got a draft together and offer it for your discussion. It does not indicate the final order. There are many issues that remain outstanding that may be covered in our order, but are not the opinions of the Court for sure at this point.

It is five after 11 now. I would like you to limit your argument to 20 minutes a side so we have time for discussion at the end as well, and I would invite comments on the proposed class definition submitted as well as on any of the matters raised in the motions for summary judgment.

The defendant started this with the filing for summary judgment, so I guess, Ms. Payton, you are first, and I would ask you to proceed with whatever comments you wish to make.

MS. PAYTON: Thank you, Your Honor.

We did appreciate getting the draft thoughts from the Court. That will allow me to focus my argument today on a number of issues that I think we want to raise with you. I will use my time on those, not necessarily everything in the order.

Obviously, Your Honor, as you would expect, we have

disagreements with the Court's draft order. I want to focus, in particular, on the part of the order which the Court concluded that it does not have to give deference to the 2020 HHS regulations on this issue.

Before I really get into that issue, I want to give you some more high-level thoughts on this case. I think it is important to think about where this case sits in this universe that we have on this issue.

As the Court knows, there is a lot of regulatory activity on this specific issue. There are a lot of cases out there that are coming fast and furious. In fact, this morning, we filed a notice of supplemental authority with no quotations from the case of an Eighth Circuit opinion that came out on many of these same issues here today. It came out late on Friday. In this case for the Court's consideration as well, I will reference that a little bit as I go forward.

I think, Your Honor, your order acknowledges this: At the end of the day, a lot of what Illinois is saying to you here, the third-party administrator in front of you is not the correct party for this particular lawsuit. There is no cause of action under Section 1557 against a third-party administrator, TPA, as a matter of law.

There is most emphatically a cause of action available for this plaintiff against the proper party, and that would be the employer that designed, implemented and funds this plan.

If the plaintiffs are correct here that the exclusion at issue is a violation of Section 1557, they have a remedy and they have a remedy against the actor who can correct that violation, if it exists.

What we have here is a lawsuit that would create an illusory victory, even if the plaintiffs were successful, because this employer can just go get a new third-party administrator. There are thousands of them. The plaintiffs have made a strategic decision, and it is creating problems because we don't have the right party in front of you, and that creates gaps and analytical jumps and all sorts of problems in the analysis that really stems from that fundamental problem.

We know the Court is aware, these transgender exclusions are common. We know that than for no other reason than we see a lot of regulatory activity on this issue and a lot of cases filed all throughout the country on this exact same issue.

This case in front of you, Your Honor, is different in the way of no other case that I am aware of in that it is against a vendor, a third-party administrator. It is not the entity that drafted or funded this exclusion.

That makes you wonder why, right? Why are we novel here sitting in the Western District that we have one of these cases against a third-party administrator?

I think that the answer may lie in the clarity of the regulations. The regulations that are sitting in existence right now and operative are clear that a third-party administrator is not responsible for a Section 1557 violation, and the regulations are emphatic through the entire course of the regulatory history that the action belongs against the employer or the ERISA group that is creating the plan design at issue.

Your Honor's draft order acknowledged there is a lot of regulatory activity on this issue. I think with respect to the regulatory issues, the questions we need to answer in this case are really two-fold. First of all, what do the regulations say? Then secondly, does this Court have to defer to them?

So I want to talk about those two questions. The first question, what do the regulations say? The regulatory history is really interesting here, right? Because we see an up and down and a change of position almost, you know, completely diametrically opposed. So we had, of course, the 2016 HHS regulations that said, I think that these exclusions violate Section 1557. Then we have the 2020 regulations come along and say two things. One, they were not violations of 1557 and made more clear what was in the 2016 regulations already, that the third-party administrator was not the proper party for 1557 violations in this context.

One reason that the 2020 regulations found that exclusion did not violate Section 1557 was that there was a good-faith disagreement on the science in this area. It wasn't an issue of animus. It was an issue of what the science was saying and what the regulatory entity said. This is not a civil rights issue. It is an issue that needs to be decided within the scientific community, and we are not going to find a categorical 1557 violation. To that point, Your Honor, that there is a legitimate debate in the science, it is acknowledged by the Ninth Circuit recently in the *Snyder* case, which acknowledges that point. We have the 2020 regs, and that is what they say.

So now we have proposed rule making from the Biden administration in 2022. And interestingly, they have been very clear about what they think they want to do. These rules are not final, of course. They haven't gone through the notice and comment period. They appear to indicate they are going to move back to the position that the exclusions are violations of 1557, but they have also reemphasized two additional things. One is that the third-party administrator is not the proper target of an enforcement action under 1557; the employer is. There is a lot of clarity around that point.

The other thing they emphasized, they are not going to visit the Religious Freedom Restoration Act issues arising

from the 2016 regulations. There, they don't want to revisit the injunction as in the *Whitman-Walker* case, such that there is a carve-out on this issue related to RFRA issues.

They have pretty much told us where they are going. We are left in the situation right now, as we sit here on December 12th of 2022, that we have operative regulations in effect that say the exclusions are allowed and that the third-party administrator is not the party that can be liable for a 15 -- a 1557 violation on this issue. Those rules cannot be -- the 2020 rules cannot be applied retroactively. Really, the situation is we do have regulations in front of you that allow the conduct that is being complained of against at least this defendant in front of you. So there really is no dispute that Illinois was complying with the operative regulation that is in place as of today.

That leaves the second question, that's the question of whether this Court can still find Illinois liable despite compliance with the regulations. That is the *Chevron* question. Here, the question is -- I think we all agree the Court must defer to the regulatory interpretation unless they are either arbitrary and capricious or the statute itself is so clear that no regulatory overlay is necessary for this Court to interpret the statute.

I think this -- Your Honor, I am honing into the big issue of where we diverge. That is the issue of whether the

Court -- whether the Court finds in the draft order that the statute is clear and you don't need the regulations. Therefore, you don't need to do the *Chevron* analysis of whether or not they are arbitrary and capricious.

Here, Your Honor, in all respects, I think the order is wrong. Numerous courts have found that Section 1557 is ambiguous on the issue of whether or not it prohibits transgender exclusion. This Court's order -- well, let me say this: To make the argument, the plaintiffs are relying on a completely separate third case which is *Bostock*. We have to look at *Bostock* to determine that it is a 1557 violation. By its very face, that is not relying on the language of the statute itself.

You know, the fact that we have had this roller coaster of regulatory regimes saying one thing then the exact opposite about the same statute is an indication that the statute is not clear and unambiguous on this particular issue. With all due respect to Your Honor, I think that is an error in the order.

I think that leads you to the next step, which is to find that you are not bound by the 2020 regulations with respect to Illinois. You need to find that the 2020 regulations are arbitrary and capricious. That is not in that draft order.

Even were you to do that, Your Honor, that wouldn't solve the problem here with this particular case because you have a

third-party administrator. The 2016, the 2020 and the 2022 proposed rule making all make it clear that it is not the liability of the third-party administrator. They give a lot of reasons why. They are the reasons I touched on before which is: This isn't the right party; not the party with control; not the party that can solve the issue; if it is indeed discrimination, it is a vendor that can be swapped out; that there are many of them and it just isn't the right way to do this.

Then on top of that, we have the problem of RFRA. Were the proper party in front of the Court on this issue, the RFRA issue would be much clearer and we wouldn't have to do this sort of convoluted analysis about RFRA.

The Supreme Court and HHS have repeatedly said that Section 1557 and RFRA must be read in conjunction together. Your Honor, I just want to be clear, this is not an issue where Illinois is saying we have a cause of action under RFRA, or we are bringing affirmative defenses under RFRA. You will find that is not in the answer.

What our argument is, is you cannot read 1557 without looking at the parameters and the boundaries of 1557 with respect to RFRA. In other words, it is one thing to say I have a cause of action under a statute. It is another thing to say that when interpreting the parameters of one statute -- here that is the Affordable Care Act -- you must

understand that its parameters are sculpted with another statute, which here is RFRA. You cannot think about the Affordable Care Act without also thinking about the boundaries created by RFRA. The Supreme Court has said that numerous times. The regulations clearly say that when they are looking at it. They don't care who the target is. They care what the statute says. That's what this Court also needs to be looking at.

Our Supreme Court has made clear you cannot -- you cannot make a TPA do something that the group would not have to do under RFRA. That is *Hobby Lobby* and that is *Sisters of the Poor* case. There, in those cases, the government claimed that it could just bypass the RFRA issues of the group by having the TPA do what the group didn't have to do. They said it is not a problem because we will even fund it. They will fund the contraception and have the TPA pay for the contraception with government funds. Our Supreme Court said no, that is still a RFRA violation. What you cannot do is cause the TPA to do something that the employer would otherwise not have to do under RFRA. That's what we are doing here. That runs afoul of what our Supreme Court has told us are the parameters of the Affordable Care Act and RFRA.

Your Honor, this is an important issue we all care about. We all care about doing the right thing. There is a lot to

balance here. There are a lot of issues, a lot of concerns, a lot of entities with a vested interest in this. A TPA is not a good defendant for this case. It is a vendor. It is not the actor with the interest at stake.

Moving ahead a little bit to your proposed order. One thing I would respectfully request the Court change is "Illinois asserts a RFRA defense." Illinois doesn't. Illinois says there are RFRA issues the Court must consider when adjudicating the parameters of the liabilities under this case. It is a slight distinction, but it is an important distinction and really goes to the issue that this is just not an action the regulators, courts, or anybody else has said can be brought against a third-party administrator and for good reasons.

The plaintiffs here are not without a proper avenue to resolution. They could sue the employer. They could sue the actor. They chose strategically not to do this. That would have given the Court the proper parties to adjudicate fulsomely.

As I said, it is an important issue. It should not be done without the proper defendant because that leads to incorrect decisions.

The operative regulations that Illinois was operating under say that these exclusions are legal. It is the 2020 regulations, and that the TPA regardless is not liable in

this situation.

With that overlay, there simply is no finding of liability against Illinois. The plaintiffs are not left without a remedy. This is just the improper way to do this.

I will sum up by saying this is ERISA. These are all ERISA self-funded plans. ERISA is about employers. Employers have the right to design plans that afford coverage to their employees. ERISA is designed to encourage employers to provide health care coverage because we have an employer-based system in the United States. We afford those employers a lot of flexibility. We give them deference in the court. We allow expedited litigation. We give encouragement for them to offer multiple plan designs that can create affordability. We incentivize them to create coverage.

What we don't want to do is bypass that system by creating substantive and significant rulings with them not present and with a vendor who is not the ultimate controller of this issue.

Again, there are a lot of third-party administrators out there. Saying no to one doesn't actually solve the issue that the plaintiffs are here saying that they want decided. It is a legitimate issue to be decided, but not with this party as a defendant.

I will stop there, unless the Court has questions for me.

THE COURT: I may have. I will defer them.

Ms. Hamburger, I am pointing at the screen, but you can't tell.

MS. HAMBURGER: Thank you, Your Honor, and good morning.

May it please the Court, I am Eleanor Hamburger.

Let me just start where Ms. Payton left off. Third-party administrators are proper defendants, both under ERISA and under Section 1557. The Ninth Circuit has long concluded that under ERISA, TPAs can be held liable for their decisions. Courts across the country have held TPAs responsible.

Not only are they responsible for their benefit decisions, but they are also responsible to follow the non-preempted federal laws. That is under 29 U.S.C. 1144(d), which defense counsel has not addressed at all in the briefing or today. This is the exact situation in *Doe vs United Behavioral Health*.

Suing a TPA is not unique. People do it all the time, because they are where the rubber hits the road when it comes to administering benefits and administering exclusions. It is the TPA that is add -- making the decisions, reviewing the claims, enforcing the exclusions. So the TPA is actually the perfect place to pursue these claims because you can in one stroke of the pen address an illegal action that is being implemented by a TPA across hundreds of employer plans, which

is exactly what is going on here.

The Affordable Care Act has no exception for covered entities that are third-party administrators.

Blue Cross's four main defenses don't solve its problems. First of all, TPAs are covered entities under Section 1557.

Defense counsel wants you to go straight to the HHS rules, but that is not what *Chevron* directs. The first stop on *Chevron* is to look at the plain language of the statute. That is exactly what this Court did in its draft opinion. The plain language of the statute says a health program cannot engage in discrimination under 1557, and it specifically calls out contracts of insurance to be included.

This was new. Very similar language had appeared in the Section 504 regulations, but the 504 regs excluded contracts of insurance. For the first time, Congress explicitly included contracts of insurance in anti-discrimination law. That was what was groundbreaking about the Affordable Care Act.

Now, many insurers have a wide -- have operations that are both insurance and third-party administrators. Employers that don't want to buy an insurance product may use the insurers to administer the plans as a TPA. That is exactly what has happened with Blue Cross Blue Shield of Illinois.

An employer can go to someone outside of like the Blue Cross Blue Shield system and get a TPA not covered by Section

1557. That's their right. We think the value of the insurers that are providing insurance and TPA services is so significant that if they can't discriminate on the basis of this section, this will not be an illusory victory. The coverage will be put in place for thousands and thousands of plans.

I always kind of laugh when a defense counsel tells you if I win, our victory will be illusory. I think that is really for us to determine.

Looking at the statute, Your Honor, the statute says health insurance is in. Blue Cross Blue Shield has among its operations health insurance on the exchange. It receives various federal financial assistance. It admits to that. It is undisputed. Then under the plain language of the statute, all of its operations are in. No need to resort to the 2020 rules on whether it is a health program or activity.

The second way that Blue Cross resorts to the 2020 rules is to say that the rules permit gender-affirming care exclusions for any reason. There is no point in the rules, no rule that they can point to where that is articulated. In fact, the 2020 rules say they are continuing the status quo.

The only place where Blue Cross Blue Shield of Illinois can rest its hat on this issue is in the preamble. The regulatory preamble is unenforceable. It makes little sense here because of the changes in the preamble language. If

Blue Cross was right, the exclusion would be illegal from 2016 to 2020, then there is this period of time where it is not illegal, and then based on the 2020 rules, it is going to be illegal again.

We ask Your Honor, as you did appropriately, to look to the plain language of the statute and to both *Bostock* and *Doe vs Snyder* to determine that under *Bostock* (inaudible) section plays an unmistakable and impermissible role in the administration of exclusion by Blue Cross Blue Shield. That is textbook sex discrimination.

Blue Cross -- the third way in which Blue Cross would like to rely on the rules instead of the statute is to say that the Court should rely on the preamble language that says TPAs -- Blue Cross says it indicates TPAs are not responsible when they administer a discriminatory exclusion for an employer. That is a misreading of the preamble. The preamble says, where the alleged discrimination relates to the administration of a plan by a covered third-party administrator, which is exactly what we allege, OCR will process the complaint against the third-party administrator because it is the entity responsible for the decision being challenged in the complaint. That is exactly what we are doing here.

Blue Cross Blue Shield standard administration red flags (inaudible) gender affirming care for denial based solely on

the diagnosis on the claim of gender dysphoria, a condition that only people who are transgender are diagnosed with.

Most importantly here, the rule -- HHS is getting it wrong when it thinks that TPAs are not responsible for following federal law that is not preempted by ERISA. A TPA does not get to evade anti-discrimination law based upon the design of the plan. They must also obey non-preempted federal law.

Finally, Your Honor, turning to the RFRA argument. The nuance that Ms. Payton is describing here, to me, is lost and does not appear in the briefing. Blue Cross is arguing that it should be protected by RFRA. It is neither an entity with a sincerely-held religious belief, nor is a government party present in this case.

Blue Cross seems to say if there are two parties and they are both private parties, no government involved, no sincerely-held religious belief, the Court should nonetheless assume a religious entity is involved and rule as if one of the parties is.

That is not what RFRA says. The plain language of RFRA limits its protections to just disputes between the government and entities with sincerely-held religious beliefs.

The *Little Sisters* case that is referenced doesn't say anything different. That case, just like the *Mercy* case referenced this morning, both involve the government and an

entity with a sincerely-held religious belief.

What is critically important here is if you rule in our favor, no employer will have to change their plan. No religious employer will have to change their plan. They just won't be able to contract with Blue Cross Blue Shield of Illinois any more to implement the exclusion.

That's because Section 1557, if it is to have any teeth, it must mean that it prohibits discrimination in all operations, even when the subject entity is operating as a TPA.

In short, there is no TPA or (inaudible) just following ordinary exclusion or exception to the Affordable Care Act. Since Blue Cross is a covered health program or activity and it is subject to 1557, it cannot administer discriminatory categoric exclusion for coverage for gender-affirming care, even when it acts as a TPA.

Just to comment on the class motion -- class -- proposed class order, we are fine with the proposed order as Your Honor drafted. The only comment is, we understood the rule to require -- to distinguish between individual claims and class claims, so we are trying to call out the individual claim for Ms. Pritchard in the proposed order. That may be something you want to consider, Your Honor, as you move to finalize the class certification order.

Unless Your Honor has other questions, I will defer the

rest of my time.

THE COURT: Ms. Payton, I guess you have an opportunity for a response, if you wish, if it is something we haven't already heard.

MS. PAYTON: I will be brief.

I think the argument that we are having here comes down to whether or not you need to defer to the 2020 rule or not. It is true, as counsel says, you can sue a third-party administrator, but that is in the context where it fails to comply with the ERISA plan. We see that over and over. When it comes to the issue of plan design, that's the employer, not the third-party administrator. It is absolutely emphatically clear from the 2020 rule that HHS concluded that the exclusions were allowed under 1557, and I quote from the federal register, but it is stated above, even if it were appropriate policy, such an end would not be achieved through the application of 1557 and Title IX. There is no statutory authority to require the provision of coverage for such procedure under Title IX protection for discrimination on the basis of sex. It is in there, and quoted in the brief.

It is very simple. Your Honor, you have an entity that is a vendor in this complicated system of employer-based health care who is operating under regulations and complying with them. It just simply is a question of whether or not -- we all may agree or disagree with the 2020 rules, but they are

the rules. Until they are changed, there really is no liability for anybody, certainly not a third-party administrator, that has been explicitly carved out by courts and by the regulator from liability in this context.

This is not -- I know the Court understands this. I want to make sure we are clear. This is not a contract of insurance. This is third-party administration, which is outside of the context of a contract of insurance. That is upheld in the regulations in that division and affirmed by numerous courts in finding the parameters of who is liable for a 1557 violation in this context.

THE COURT: Hold on a minute. You can watch something that most people don't get to see. I have to change my batteries. It becomes very difficult to hear if I don't do that because the computer puts the sound right through my telephone and into my hearing aid. I got the signal just as we were starting that I was getting low, my battery level. We will change the batteries and then we will be ready to go.

Okay. Somebody talk to me.

MS. PAYTON: How about this. Does it sound good?

THE COURT: It sounds good. Problems of aging.

You know, as we have worked on this, we have had sort of a double approach. One is the plaintiffs are asking for an injunction that directs Blue Cross not to decline coverage on

the gender dysphoria issue. Then there is another angle about who pays if the Court goes along with the plaintiffs' theories.

Are there two issues that are separate there? Can Blue Cross be directed to change its instructions without incurring financial liability? Of course, the liability of the plaintiffs is comparatively small as compared to all of the potential liability in pending matters.

Any comments on that?

MS. HAMBURGER: Let me go first since our suggestion has been that we brief the remedies for you in this case.

You know, I would break it down a little bit differently. I would say we have kind of three potential remedies here. One is the injunctive relief going forward, which does not have an impact on who pays because Blue Cross would have to notify its employers that this was happening. Those employers that didn't want to pay for it could go find other TPAs. The prospective relief does not hit the "who pays" issue because the employers that stay will obviously be on the hook to pay.

Second, the retrospective reprocessing we have asked for, we believe it is Blue Cross's liability. It was Blue Cross's responsibility under the administrative services agreement to always comply with the law. It is Blue Cross's responsibility to fully comply with the statute. So we

believe that any damage related to uncovered medical expenses is borne by Blue Cross Blue Shield of Illinois.

That said, as a contract matter, Blue Cross has indemnification agreements with every single employer that it administered this exclusion for. Even if Your Honor orders Blue Cross to pay, Blue Cross, outside of this courtroom, has a means of redress with those employers under their existing indemnity provisions.

I would suggest, Your Honor, and we will do this in the briefing, that that's between them. They will work it out or they won't work it out. What is important is the reprocessing occur. Blue Cross would pay for it, and then sort it out with the employers how they are going to handle it.

The third issue we think is outstanding is how are we going to handle Pattie Pritchard's individual damages, the $12,000, which is small. Blue Cross did not dispute that in the briefing that we did. We think that is ripe for adjudication. If you want to wait to have it addressed in remedies briefing, that is also fine. That's how we see those three issues.

MS. PAYTON: I agree with Ms. Hamburger that this issue merits additional briefing to the Court. I would love to get a schedule in place to do that.

A couple of precursors on the problem we have here.

Your Honor has certified a (b)(1)/(b)(2) class. It cannot have monetary damages. It can be injunctive relief only. This whole idea, while Illinois can just pay the claims, that's money damages. That cannot be allowed in what the Court has done. There is also a requirement that any relief afforded under Rule 23 be final. We have a myriad of cases saying you can't issue an injunction that will be the beginning of a process to find a resolution of the claim. Reprocessing, getting employers to pay, whatever it may be, outside of the parameters of what the Court has conducted under Rule 23, cannot do that. That is as clear as anything under the law.

We have a double problem here. They just told you they are seeking money, which they cannot do under the class that they have certified.

Secondly, they have told you that alternately it would be something that someone can (inaudible). That cannot happen under Rule 23. That remedy fails and does not satisfy Rule 23, and we'll be glad to brief that in addition.

THE COURT: Another question. I think in general terms, I have thought of RFRA as a defense that may be raised. I haven't thoroughly analyzed that, but that has been my impression. If it is a defense that the payors under these policies have to raise, at what point do they raise it and how is it raised? I don't see how -- well, I am not as

familiar with TPAs perhaps as I should be, but I don't see how someone that is managing insurance can make a decision that can go along with their daily work in what is covered by some religious or other exception to the work they are doing. How are they going to do that? Here, we have this letter that says CHI is the Catholic organization. What do you draw from that? I don't know how that turns this particular plan into one that is totally covered by RFRA. I guess part of the thought that passed through my mind here is let them have a rule that they tell people your claim is covered under the law, but there may be some exception when you go to the doctor. There may be some limit in the actual application for services if someone says we can't do this because of the religious issue and then have to prove it on a case-by-case basis, which obviously doesn't sound like a very practical result.

Anyway, those are thoughts about RFRA. I would be interested in comments you have on that.

You go first, Ms. Hamburger.

MS. HAMBURGER: Thank you, Your Honor.

I think there are complicated issues about RFRA, but none of them enter into this case because, for whatever reason, CHI has not shown up. They clearly have some relationship going on with Blue Cross Blue Shield of Illinois, but they decline to submit any declaration or to participate in any

way in this case. So we don't know if the hospital at which Ms. Pritchard works is subject to any religious exemption. In fact, there is evidence in the record that even CHI considers the facility that Ms. Pritchard is at, what used to be Harrison Medical Center, to be part of CHI's for-profit arm and not subject to the religious exemption.

Yes, there are a lot of complications, but I don't believe we have evidence in this case that necessarily means that there is a party in here with a sincerely-held religious belief that needs to be accommodated. That's my response on that.

These questions will have to be sorted out. I am sure they will be sooner or later.

Where you have a third-party administrator with no sincerely-held religious belief that is subject to 1557, there is no exception for that TPA. Those employers that may or may not have an exception, they can find a different TPA to administer their coverage. That seems to me the answer to that issue here, for this case.

THE COURT: Ms. Payton.

MS. PAYTON: This, Your Honor, is why every single court, every single court and regulator have said the party is the group when you are enforcing 1557 because they are the ones that are dealing with the panoply of issues that come into 1557. We have the United States Supreme Court and

numerous other courts saying when you analyze the Affordable Care Act and 1557, in particular, you must also consider the parameters of RFRA. You can't do an end run around RFRA, but go after the TPA. That is *Hobby Lobby* and *Sisters of the Poor*.

This problem is created by having the wrong defendant in front of the Court. We do, however, have the only evidence, and it is uncontradicted in the case, of a letter to these named plaintiffs saying the exclusion was included for religious beliefs. That is in this record. We can go beyond that. We know from the ample number of cases brought by Catholic institutions throughout the United States, all of these leading cases enforcing and upholding these exclusions are from Catholic institutions. Nobody is contesting these are bona fide, good faith, religiously-held views. They are important. It is impossible to adjudicate a 1557 claim without taking them into consideration.

One thing we know from *Hobby Lobby* is that it is not just the name of the group that you can tell. In *Hobby Lobby*, it was the shareholders that had the bona fide religious view that was protected by the RFRA defense in that case.

What we have here is the wrong party to even make that analysis. So we have a problem we know is real. Right? We know that RFRA is an issue here, and it will stop the payment of many of these claims. Maybe not all of them. Maybe some

of them. We don't have that information in front of this Court right now. We know there has to be some sort of mechanism before affording relief to determine that. We simply cannot do that within the parameters of this class.

This goes back to what I was saying at the beginning of this discussion, which you have an injunctive class that cannot afford monetary damages and then you don't have finality because you don't really have the people in front of you to make a determination of whether these claims should be paid or not. We simply don't have means to give final relief in this particular case.

There is really no legitimate question from anybody who has analyzed Section 1557, courts, regulators, that you should do that in a vacuum outside of the RFRA issues. You cannot do that if you don't have the RFRA entity in front of you. They are real, and they are here.

I will note, Your Honor, that at the beginning of this case we moved under Rule 19, indispensable parties. Many of these entities (inaudible) because Blue Cross Blue Shield of Illinois only administers plans for groups that are headquartered in the state of Illinois. This case really doesn't have a lot of nexus to the state of Washington. We do have a plaintiff who resided in the state of Washington. All of the employer groups are based in the state of Illinois. Many of them are not subject to the jurisdiction

of this Court. We have a really peculiar situation going on here.

When I started this argument, I said to Your Honor, a lot of problems that we have here, and they are real problems that we have to sort through, are created by the fact we have a TPA and not a group. That is why -- that is why the courts and the regulators say you need to deal with the group on this issue, not the TPA. They have said it clearly. They said it explicitly. They said it over and over since 2016. None of the rulemaking has changed on that issue. The Biden administration has doubled down on that and made it very clear they are not going to do this with a TPA for many of the reasons we are running into here. We just can't figure it out unless we have the institutions that are responsible for these claims in front of us. An injunctive order saying reprocess these claims does not satisfy Rule 23 because we get to a stop. Rule 23 doesn't (inaudible).

THE COURT: Let me ask you: How does Blue Cross feel about being required to give what basically could be contrary advice that forecloses coverage that perhaps should be allowed? Doesn't it put Blue Cross in a position where you are putting out bad information to your patients, or potentially bad, at least?

MS. PAYTON: Let me say it this way, Your Honor: What Blue Cross's position is, is it wants to comply with the

law. It wants to have the law to be consistent through the industry, right? So we are not just putting one business out of business. That is one consideration in Rule 23. There are thousands of third-party administrators out there. They all have these exclusions. We have Aetna, Signa, United Health, all the Blue Cross Blue Shield plans. They are all doing this. What Blue Cross wants to know is what the law is, to follow the law and to be consistent with the rest of the industry so it can still operate. Otherwise, what you are doing is targeting and put a death knell on one carrier and not on the rest. That really does nothing on this issue. We do want an answer on this issue. We want to do the right thing. We want to follow the law.

It is very hard to know what is going on here. You have an entity in good faith following the regulatory regime that it was subjected to. It did. It did everything required under those regulations. Were the regulations to change, it would comply with the changed regulations. It is not the actor that has the interest in this issue.

It is really peculiar because I don't think there has been any argument that Blue Cross Blue Shield of Illinois violated the regulatory regime that it lives under. It is the obstruction (inaudible) of, well, it might have been illegal for somebody else, therefore it is illegal for you. That's just not how the law works.

To your question of what are we going to tell people about this, I don't know. It is very unclear what is going on here because we cannot afford the relief that the plaintiffs are requesting. We simply do not have the power to do this. There was nothing, absolutely nothing, Your Honor, stopping them from suing the entity that did. They chose not to do that. That is the plaintiffs' burden.

THE COURT: Okay. Ms. Hamburger, quickly.

MS. HAMBURGER: Yes, Your Honor, there is no -- plaintiffs get to chose their defendant. It is clear we have a cause of action against TPAs. TPAs are correctly subject to this law if they are a covered health entity, which we believe your draft decision found that they are.

Blue Cross Blue Shield of Illinois represented to its members, to its enrollees, to the Pritchards, in every letter they included a tag line "we do not discriminate on the basis of sex." They promised they wouldn't do that time and time again in every communication with these plaintiffs. They also promised in their contract with Blue Cross -- with CHI and with other employers that they would always follow the relevant federal law.

The failure to follow 1557 and to not discriminate on the basis of sex rests solely with Blue Cross Blue Shield of Illinois. They did their own analysis when the ACA came out and concluded in 2015 that they were going to remove these

exclusions from all of their insured plans. They understood they needed to follow this law in their insured plans, but because they wanted to keep the business of the entities that wished to continue to discriminate, they agreed to administer the exclusions putting their own financial interest ahead of the promises they made to the Pritchards. That responsibility for following the law rests solely at Blue Cross Blue Shield of Illinois' feet.

THE COURT: Okay. It is quitting time for me. Only for an hour or so for lunch and then we will dive into this further and try and get everything back to you as soon as we can. It will take a little while.

Okay. Thank you very much.

MS. PAYTON: Thank you.

MS. HAMBURGER: Thank you.

MS. PAYTON: Good-bye, everyone.

(The proceedings adjourned.)

C E R T I F I C A T E

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Angela Nicolavo

ANGELA NICOLAVO
COURT REPORTER

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard, individually and on behalf of others similarly situated; and PATRICIA PRITCHARD, Plaintiff, v. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	CASE NO. 3:20-cv-06145-RJB AMENDED ORDER CERTIFYING CLASS

This matter comes before the Court *sua sponte* on review of the record. The Court has reviewed the record and is fully advised.

On November 9, 2022, a class was certified in this case. Dkt. 113. The Court issued an order noting that orders on class certifications can be amended before final judgment under Fed. R. Civ. P. 23(c)(1)(C) and that the one entered in this case should have included the "class claims, issues and defenses." Dkt. 119. The Plaintiffs were ordered to file a proposed amended

order. *Id.* On November 29, 2022, the Plaintiffs filed a proposed order recommending that the Court adopt the claims and relief sought as they appear in the Amended Complaint. Dkt. 131.

The order certifying a class in this case should be amended (with the newly added provisions in bold) to read as follows:

The class is composed of all individuals who:

> (1) have been, are, or will be participants or beneficiaries in an ERISA self-funded "group health plan" (as defined in 29 U.S.C. § 1167(1)) administered by Blue Cross Blue Shield of Illinois during the Class Period and that contains a categorical exclusion of some or all Gender-Affirming Health Care services; and
>
> (2) were, are, or will be denied pre-authorization or coverage of treatment with excluded Gender Affirming Health Care services
>
> DEFINITIONS:
>
> "Class Period" means November 23, 2016 through the termination of the litigation.
>
> "Gender-Affirming Health Care" means any health care service—physical, mental, or otherwise—administered or prescribed for the treatment of gender dysphoria; related diagnoses such as gender identity disorder, gender incongruence, or transsexualism; or gender transition. This includes but is not limited to the administration of puberty delaying medication (such as gonadotropin-releasing hormone (GnRH) analogues); exogenous endocrine agents to induce feminizing or masculinizing changes ("hormone replacement therapy"); gender-affirming or "sex-reassignment" surgery or procedures; and other medical services or preventative medical care provided to treat gender dysphoria and/or related diagnoses, as outlined in World Professional Association for Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version (2012).

The class asserts claims that Blue Cross Blue Shield of Illinois violated the anti-discrimination provision of the Affordable Care Act, 42 U.S.C. § 18116, when it administered discriminatory exclusions of gender-affirming care in a self-funded health care plans governed by the Employee Retirement Income Security Act of 1974.

The class seeks declaratory relief. They seek an order enjoining Blue Cross Blue Shield of Illinois from administering or enforcing health benefit plans that exclude coverage for gender-affirming health care, including applying or enforcing the plans' exclusions of services for, or leading to, gender reassignment surgery,' and other similar exclusions during the class period, now and in the future. The class seeks an order requiring Blue Cross Blue Shield of Illinois to reprocess denied pre-authorizations and claims for gender affirming care under the relevant self-funded health care plans without applying the discriminatory exclusions, and when medically necessary and meeting the other terms and conditions of the relevant plans, provide coverage (payment) for those denied pre-authorizations and claims that were based solely on exclusions for gender affirming care.

Blue Cross Blue Shield of Illinois raises several defenses, including that the anti-discrimination provision of the Affordable Care Act, 42 U.S.C. § 18116 does not apply to it, and even if it did, its third-party administration of the exclusions was not discriminatory. Blue Cross Blue Shield also contends that it is protected by the Religious Freedom Restoration Act.

Plaintiff C.P., by and through his parents, is appointed as class representative, and

Eleanor Hamburger and Daniel Gross of Sirianni Youtz Spoonemore Hamburger, as well as Jennifer Pizer and Omar Gonzalez-Pagan of the Lambda Legal Defense and Education Fund are appointed as class counsel.

The reasoning from the prior order (Dkt. 119) applies.

IT IS SO ORDERED.

The Clerk is directed to send uncertified copies of this Order to all counsel of record and to any party appearing pro se at said party's last known address.

Dated this 12th day of December, 2022.

ROBERT J. BRYAN
United States District Judge

No. 23-4331

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

C. P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, *et al.*,

Plaintiffs-Appellees,

v.

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant-Appellant.

On Appeal from the United States District Court for the Western District of Washington, Hon. Robert J. Bryan, District Judge (No. 3:20-cv-06145-RJB)

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Exhibit 5

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

EXHIBIT L

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

Wylie C. Hembree,[1] Peggy T. Cohen-Kettenis,[2] Louis Gooren,[3] Sabine E. Hannema,[4] Walter J. Meyer,[5] M. Hassan Murad,[6] Stephen M. Rosenthal,[7] Joshua D. Safer,[8] Vin Tangpricha,[9] and Guy G. T'Sjoen[10]

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*Cosponsoring Associations: American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society–appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

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Abbreviations: BMD, bone mineral density; DSD, disorder/difference of sex development; DSM, Diagnostic and Statistical Manual of Mental Disorders; GD, gender dysphoria; GnRH, gonadotropin-releasing hormone; ICD, International Statistical Classification of Diseases and Related Health Problems; MHP, mental health professional; VTE, venous thromboembolism.

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. (***J Clin Endocrinol Metab*** **102: 3869–3903, 2017)**

Summary of Recommendations

1.0 Evaluation of youth and adults

1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

doi: 10.1210/jc.2017-01658

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 |⊕⊕◯◯)

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 |⊕⊕⊕◯)

2.0 Treatment of adolescents

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 |⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 |⊕⊕◯◯)

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕◯◯)

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 |⊕⊕◯◯).

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 |⊕⊕◯◯)

3.0 Hormonal therapy for transgender adults

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕◯◯◯)

4.0 Adverse outcome prevention and long-term care

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕◯◯)

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 |⊕⊕◯◯)

4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕◯◯)

4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕◯◯)

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 |⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 |⊕◯◯◯)

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

5.0 Surgery for sex reassignment and gender confirmation

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 |⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 |⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 |⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 |⊕◯◯◯)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕◯◯◯ denotes very low–quality evidence; ⊕⊕◯◯, low quality; ⊕⊕⊕◯, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

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values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these "Ungraded Good Practice Statement." Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society's Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline's development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [*e.g.*, stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers' bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are "trapped" in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote "The Transsexual Phenomenon" (4), it was Hirschfeld who coined the term "transsexual" in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through "something in between" to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (*e.g.*, Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (*e.g.*, the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

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Table 1. Definitions of Terms Used in This Guideline

Biological sex, biological male or female: These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (*e.g.*, a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.
Cisgender: This means not transgender. An alternative way to describe individuals who are not transgender is "non-transgender people."
Gender-affirming (hormone) treatment: See "gender reassignment"
Gender dysphoria: This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced "gender identity disorder" with "gender dysphoria" and changed the criteria for diagnosis.
Gender expression: This refers to external manifestations of gender, expressed through one's name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.
Gender identity/experienced gender: This refers to one's internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.
Gender identity disorder: This is the term used for GD/gender incongruence in previous versions of DSM (see "gender dysphoria"). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using "gender incongruence of childhood."
Gender incongruence: This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity–related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.
Gender variance: See "gender incongruence"
Gender reassignment: This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.
Gender-reassignment surgery (gender-confirming/gender-affirming surgery): These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.
Gender role: This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.
Sex designated at birth: This refers to sex assigned at birth, usually based on genital anatomy.
Sex: This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.
Sexual orientation: This term describes an individual's enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.
Transgender: This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.
Transgender male (also: trans man, female-to-male, transgender male): This refers to individuals assigned female at birth but who identify and live as men.
Transgender woman (also: trans woman, male-to female, transgender female): This refers to individuals assigned male at birth but who identify and live as women.
Transition: This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.
Transsexual: This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called "desisters"). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people's lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

A. A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender
   4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
   1. The condition exists with a disorder of sex development.
   2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

Reference: American Psychiatric Association (14).

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of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)

1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:
1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

1. A qualified MHP has confirmed that:
- the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
- gender dysphoria worsened with the onset of puberty,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
- the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,

2. And the adolescent:
- has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment
- agrees with the indication for GnRH agonist treatment,
- has confirmed that puberty has started in the adolescent (Tanner stage ≥G2/B2),
- has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP has confirmed:
- the persistence of gender dysphoria,
- any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
- the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,

2. And the adolescent:
- has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
- has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,

3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:
- agrees with the indication for sex hormone treatment,
- has confirmed that there are no medical contraindications to sex hormone treatment.

Reproduced from World Professional Association for Transgender Health (16).

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reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 ⊕⊕◯◯)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 ⊕⊕⊕◯)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the "normal range" (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 ⊕⊕◯◯)

2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 ⊕⊕◯◯)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

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barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 |⊕⊕◯◯)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:
1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:
1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 ml

Adapted from Lawrence (56).

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after "gender-reassignment surgery" (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD *z* scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD *z* scores and of bone mineral apparent density *z* scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (±1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (±1.4) years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (±2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD *z* scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog–treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D–deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog–treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

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want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 |⊕⊕◯◯)

2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 |⊕◯◯◯)

2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 |⊕⊕◯◯)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β-estradiol, increasing the dose every 6 mo:
5 μg/kg/d
10 μg/kg/d
15 μg/kg/d
20 μg/kg/d
Adult dose = 2–6 mg/d
In postpubertal transgender female adolescents, the dose of 17β-estradiol can be increased more rapidly:
1 mg/d for 6 mo
2 mg/d
Induction of female puberty with transdermal 17β-estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
6.25–12.5 μg/24 h (cut 25-μg patch into quarters, then halves)
25 μg/24 h
37.5 μg/24 h
Adult dose = 50–200 μg/24 h
For alternatives once at adult dose, see Table 11.
Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).
Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
25 mg/m^2/2 wk (or alternatively, half this dose weekly, or double the dose every 4 wk)
50 mg/m^2/2 wk
75 mg/m^2/2 wk
100 mg/m^2/2 wk
Adult dose = 100–200 mg every 2 wk
In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:
75 mg/2 wk for 6 mo
125 mg/2 wk
For alternatives once at adult dose, see Table 11.
Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).

Adapted from Hembree *et al.* (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo
•Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
•In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
•In transgender females: prolactin, estradiol, 25OH vitamin D
Every 1–2 y
•BMD using DXA
•Bone age on X-ray of the left hand (if clinically indicated)
BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).
For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree *et al.* (118).

Abbreviation: DXA, dual-energy X-ray absorptiometry.

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for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β-estradiol may be an alternative for oral 17β-estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 "Hormonal Therapy for Transgender Adults").

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 |⊕⊕⊕◯)

3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 |⊕⊕⊕◯)

3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 |⊕⊕◯◯)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 "Adverse Outcome Prevention and Long-Term Care") and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen
Very high risk of adverse outcomes:
•Thromboembolic disease
Moderate risk of adverse outcomes:
•Macroprolactinoma
•Breast cancer
•Coronary artery disease
•Cerebrovascular disease
•Cholelithiasis
•Hypertriglyceridemia
Transgender male: testosterone
Very high risk of adverse outcomes:
•Erythrocytosis (hematocrit > 50%)
Moderate risk of adverse outcomes:
•Severe liver dysfunction (transaminases > threefold upper limit of normal)
•Coronary artery disease
•Cerebrovascular disease
•Hypertension
•Breast or uterine cancer

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Table 11. Hormone Regimens in Transgender Persons

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

[a]Estrogens used with or without antiandrogens or GnRH agonist.

[b]Not available in the United States.

[c]One thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

[d]Avoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5α-Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17β-estradiol, or transdermal 17β-estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the "first pass effect" than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (*e.g.*, male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 |⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and antiandrogen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

[a] Prevention and treatment as recommended for biological men.

[b] Menorrhagia requires diagnosis and treatment by a gynecologist.

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Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

[a]Complete removal of male sexual hair requires electrolysis or laser treatment or both.

[b]Familial scalp hair loss may occur if estrogens are stopped.

[c]Treatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone–induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 |⊕⊕◯◯)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a] Adapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 l⊕⊕◯◯)

Evidence

Estrogen therapy can increase the growth of pituitary lactrotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

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4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕◯◯)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low–quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕◯◯)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pretreatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (*e.g.*, when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 l⊕⊕◯◯)

4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 l⊕◯◯◯)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1 30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

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provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the "threshold of 18 should not be seen as an indication in itself for active intervention." If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologuous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (*e.g.*, cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕◯◯)

5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)

5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)

5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕◯◯◯)

5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕◯◯).

5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕◯◯◯)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

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causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

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Exhibit M

Catholic Health Initiatives

Imagine better health.®

well-being

Summary Plan Description — Medical (Franciscan Health)

Blue Cross Blue Shield Integrated

Effective January 1, 2019

imagine your ***Best Self***

2019 Summary of Modifications

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

Summary of Modifications

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

Who to Contact With Questions

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

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

Table of Contents

Medical Plan Introduction

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

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

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

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

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

A copy of this SPD is available online by either:

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

Important Information

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

Charts and Call-Out Boxes

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

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

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

Complete Information

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

Most information on Benefits will be found in these sections:

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

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

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

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

Highlights of the Medical Plan Options

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

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

A Snapshot of the Medical Plan

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

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

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

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

Summary of Benefits

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

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

Summary of Benefits Continued

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

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

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

Summary of Benefits Continued

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

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

Pharmacy Summary of Benefits

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

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

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

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

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

Health Savings Account

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

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

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

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

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

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

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

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

The IRS has regulations regarding enrollment in an HSA:

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

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

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

Quick Reference — What's Covered and Not Covered

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

The chart on the following page provides the following information:

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

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

Not Covered – The listed category is generally not covered.

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

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

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

Quick Reference - What's Covered and Not Covered

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

Quick Reference Continued

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

Quick Reference Continued

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

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

Adding or Dropping Coverage

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

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

Eligibility

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

Your Coverage

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

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

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

Your Dependent's Coverage

Dependents eligible for the Medical Plan include:

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

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

Dependent Eligibility Audit

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

- Medical Plan
- Dental Plan
- Vision Plan

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

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

Pre-existing Conditions Waiting Period

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

Enrolling in Benefits

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

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

Enrollment Process

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

Type of coverage includes:

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

Your Cost of Coverage

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

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

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

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

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

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

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

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

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

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

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

Qualifying Events for Changing Your Coverage:

Change in legal marital status
Must notify Plan within 31 days

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

Change in number of dependents
Must notify Plan within 60 days

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

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

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

Other qualifying events
Must notify Plan within 31 days

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

Consistency Rule

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

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

Qualified Medical Child Support Orders

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

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

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

Dual Coverage Under This Plan is Prohibited

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

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

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

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

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

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

Your ID Card

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

Medicare Eligible Persons and Their Enrollment in This Plan

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

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

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

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

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

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

Your Medicare Secondary Payer (MSP) Responsibilities

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

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

What You Pay — A Tutorial

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

The Medical Plan uses three networks:

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

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

Payments for CHI Facilities

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

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

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

How the Plan Pays for Office Visits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How the Plan Pays for Preventive Care

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

How the Plan Pays for Urgent Care Visits

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

How the Plan Pays for Emergency Room Visits

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

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

How to Save Money When Purchasing Prescription Drugs

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

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

How the Deductible Works

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

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

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

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

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

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

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

How Does the Family Deductible Work?

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

Example #1:

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

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

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

**Total amount paid as preventive service. Deductible does not apply.*

*** As a reminder, each plan has a family Deductible. Individual Deductibles are combined to meet the family Deductible.*

‡Deductible has been satisfied. Balance of Eligible Charge will be paid at applicable Coinsurance percentage.

Example #2:

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

Each family member has the following Eligible Charges:

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

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

How Copayments Work

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

How Coinsurance Works

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

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

How the Out-of-Pocket Maximum Works

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

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

There Are Three Different Levels of Benefits

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

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

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

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

The Details — What's Covered and Not Covered

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

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

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

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

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

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

Abortions

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

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

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

Acupuncture

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

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

Allergy Testing and Treatment

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

Ambulance Transportation

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

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

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

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

Ambulatory Surgical Facilities

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

Anesthesia Services

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

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

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

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

Applied Behavior Analysis (ABA) Therapy

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

Assistant Surgeons

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

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

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

Blood and Blood Administration

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

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

See Also:
Surgery later in this section.

Cardiac Rehabilitation Services

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

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

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

Chemotherapy Treatments

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

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

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

Chiropractic Care

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

Completion of Claim Forms, Reports, or Medical Records

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

Contraceptives and Contraceptive Devices

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

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

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

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

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

See Also:
Sterilization Procedures later in this section.

Cosmetic Surgery

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

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

See Also:
Surgery later in this section.

Consultations

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

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

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

Custodial Care Services

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

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

Cyber Knife Surgery

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

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

Dental Services

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

Coverage for dental services is limited to the following:

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

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

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

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

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

Diabetes Training Programs

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

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

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

Diagnostic Services

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

See Also:
Genetic Testing later in this section.

Digital Breasts Tomosynthesis (3D Mammograms)

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

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

Durable Medical Equipment

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

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

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

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

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

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

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

Educational or Training Programs

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

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

See Also:
Diabetes Training Programs earlier in this section.

Eligible Charges for Multiple Surgical Procedures

Covered:

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

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

Emergency Services

Covered:

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

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

Not Covered:

You may be billed for the difference between the Medicare allowed and the provider billed charges.

See also:

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

Eye Examinations and Eye-Related Diagnostic Services

Covered:

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

Not Covered:

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

See Also:

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

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

Eyeglasses, Contact Lenses, or Cataract Lenses

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

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

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

Failure to Keep a Scheduled Appointment

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

Family Members Who Provide Services

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

Fertility Treatment

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

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

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

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

Foot Care and Foot Orthotics

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

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

Genetic Testing

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

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

See Also:
Diagnostic Services earlier in this section.

Hearing Examinations and Hearing Aids

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

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

Home Health Care

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

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

- Laboratory services;

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

The home health care services must be rendered in accordance with a prescribed Home Health Care Plan. The Home Health Care Plan must be:
- Established prior to the initiation of the home health care services;
- Prescribed by the attending Physician at least once every 30 days; and
- Required as a result of an Illness or Accidental Injury.

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

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

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

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

Hospice Care Program Services

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

The following are eligible Hospice Care Program Providers:
- Hospice facility;
- Hospital;
- Convalescent facility; and
- Home Hospice.

The following services are covered under the Hospice Care Program:

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

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

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

Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary

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

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

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

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

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

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

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

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

Human Organ Transplants

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

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

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

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

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

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

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

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

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

Inpatient Hospital Care

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

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

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

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

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

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

Kerato-Refractive Eye Surgery

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

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

Leg, Back, Arm and Neck Braces

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

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

Marriage Counseling

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

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

Massage Therapy

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

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

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

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

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

Mastectomy and Related Services

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

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

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

Maternity Services

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

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

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

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

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

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

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

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

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

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

Mental Health Services

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

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

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

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

Modifications to Homes, Property, or Automobiles

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

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

Nephropathy Screening

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

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

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

Non-Emergency Use of the Emergency Room

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

See Also:
Emergency Services earlier in this section.

Non-Prescription Drug Medications

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

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

See Also:
Prescription Drugs later in this section.

Occupational Therapy

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

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

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

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

Office Visits

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

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

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

Outpatient Hospital Care

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

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

Outpatient Hospital care does not require pre-notification.

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

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

"-ologists" at In-Network and CHI Facilities

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

Not Covered:
This does not apply to assistant surgeons.

See Also:
Anesthesia Services earlier in this section.

Optometry Services

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

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

Oxygen and Its Administration

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

Personal Hygiene, Comfort, and Convenience Items

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

See Also:
Inpatient Hospital Care earlier in this section.

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

Physical Therapy

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

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

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

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

Physicians

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

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

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

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

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

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

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

Pre-Admission Testing

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

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

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

Prenatal Care Program

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

See Also:
Maternity Services earlier in this section.

Prescription Drugs

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

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

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

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

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

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

Preventive or Wellness Care

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

Covered services include but are not limited to the following:

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

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

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

Prosthetic Appliances and Devices

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

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

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

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

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

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

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

Radiation Therapy Treatments

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

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

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

Residential Treatment Facilities

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

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

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

Retinal Eye Exam

Covered:
Benefits for retinal eye exams for diabetic patients.

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

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

Routine Physical Exams

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

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

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

Shock Therapy Treatments
Covered:
Benefits will be provided for shock therapy treatments.

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

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

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

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

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

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

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

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

See Also:
Preventive or Wellness Care earlier in this section

Speech Therapy

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

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

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

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

Sterilization Procedures

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

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

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

Substance Abuse Rehabilitation Treatment

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

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

See Also:
Residential Treatment Facilities earlier in this section.

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

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

Temporomandibular Joint Dysfunction and Related Disorders
Covered:
Benefits shall be provided for TMJ Surgery.

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

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

Travel or Lodging Costs

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

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

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

Vision Services

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

Not Covered:
Benefits shall not be provided for:

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

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

Web Cam Consultations

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

See Also:
Consultations earlier in this section.

Weight Loss Prescription Drugs

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

Weight Loss Surgery

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

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

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

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

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

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

See Also:
Surgery earlier in this section.

Wigs or Hair Pieces

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

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

See Also:
Chemotherapy Treatments earlier in this section.

X-Ray and Laboratory Services

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

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

CHI Wellness Program

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

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

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

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

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

Weight Watchers

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

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

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

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

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

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

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

General Conditions of Coverage, Exclusions, and Limitations

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

General Conditions of Coverage

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

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

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

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

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

General Exclusions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Benefit Limitations

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

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

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

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

Network Details — Choosing a Provider

Choosing Your Medical Providers

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

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

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

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

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

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

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

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

The Three Levels of Benefits Available to You

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

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

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

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

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

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

Choosing a Pharmacy

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

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

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

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

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

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

Mail-Order Pharmacy

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

Medical and Pharmacy Notification Requirements and Care Coordination

Your Medical Care

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

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

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

- Emergency Inpatient Hospital stays; and
- Maternity stays.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Condition Management Program

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

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

Diabetes Care Program

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

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

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

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

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

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

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

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

Obtaining Prescriptions

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

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

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

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

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

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

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

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

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

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

Medical and Pharmacy Claims Procedures

Your Medical Claims

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Prescription Claims

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

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

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

Mail-Order Pharmacy Claims

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

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

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

Benefits of Using the Mail-Order Pharmacy

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

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

The CHI Prescription Plan Formulary

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

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

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

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

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

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

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

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

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

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

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

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

Coordination of Your Benefits with Other Plans and Responsible Parties

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

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

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

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

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

This is done by following the rules below:

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

be determined before the Benefits of a program which covers that Child as a Dependent of the step-parent, and the Benefits of a program which covers that Child as a Dependent of the stepparent will be determined before the Benefits of a contract which covers that Child as a Dependent of the parent without custody; and
    - Notwithstanding the items above, if there is a court decree which would otherwise establish Financial Responsibility for the medical, dental, or other health care expenses with respect to the Child, the Benefits of a program which covers the Child as a Dependent of the parent with such Financial Responsibility shall be determined before the Benefits of any other program which covers the Child as a Dependent Child. It is the obligation of the person claiming Benefits to notify the Medical Plan, and upon its request to provide a copy of such court decree.
- If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

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

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

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

In order to prevent duplicate payment of Benefits for a Claim, the Medical Plan uses the following process to determine Benefits when it is the secondary payor:
- Determine what the Benefit for services would be under the provisions of the Medical Plan; and
- Deduct from this resulting amount the amount paid by the primary payor. The difference is the Benefit that will be paid under the Medical Plan.

Rights to Reduction, Reimbursement, and Subrogation

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Provisions
The following provisions also apply:

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

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

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

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

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

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

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

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

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

Appealing an Eligibility Claim

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

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

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

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

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

Appealing a Denied Medical or Pharmacy Claim

Notification of Adverse Benefits Determinations

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

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

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

Appeal Process for Medical Claims

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

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

Post-Service Claim Appeals Process

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

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

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

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

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

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

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

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

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

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

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

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

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

Pre-Service Claim Appeals Process

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

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

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

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

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

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

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

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

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

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

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

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

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

External Review

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

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

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

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

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

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

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

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

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

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

Appeal Process for Prescription Drug Claims

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

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

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

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

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

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

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

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

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

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

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

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

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

Termination of Coverage and Coverage Continuation

Termination of Coverage

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

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

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

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

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

Severance Pay

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

- Medical Plan
- Dental Plan
- Vision Plan

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

Continuation of Coverage (COBRA)

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

Introduction

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

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description (SPD) or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse/Legally Domiciled Adult and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare Benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child is no longer eligible for coverage under the Plan as a "Dependent Child."

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

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

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

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

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

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

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

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

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

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

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

Your request must also include the following:

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare Benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Determining Your Contributions for Continuation Coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36-month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29-month period, contributions for coverage during the extended disability period may never exceed 150 percent of the plan costs.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at http://www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COBRA Contact Information

Discovery Benefits
P.O. Box 2079
Omaha, NE
68108-2079
1-866-451-3399

Family Medical Leave (FMLA)
If CHI grants you an approved family or medical leave (approved FMLA leave) leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by CHI.

If CHI grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue health Benefits for you and your eligible Dependents. At the time you request the leave, you must agree to make any required contributions to continue coverage.

If any coverage CHI allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date CHI determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues. However, health coverage may be available to you under another plan sponsored by CHI.

Any coverage being continued for a Dependent will not be continued beyond the date it would otherwise terminate.

If Benefits terminate because your approved FMLA leave is deemed terminated, you may, on the date of such termination, be eligible for continuation under federal law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined Dependent), you (or your eligible Dependents) may be eligible for such continuation on the date CHI determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new Dependent while your coverage is continued during an approved FMLA leave, the Dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for CHI following the date CHI determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date CHI determines the approved FMLA leave to be terminated. If you

do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because CHI determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date CHI determines the approved FMLA leave is terminated.

General Plan Provisions and Your Rights Under ERISA

Group Benefit Plan Notice of Privacy Practices

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Catholic Health Initiatives (CHI) health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Prescription Drug, Dental, Vision, EAP, Flexible Benefits and Wellness plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you
The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not *CHI* as an employer — that's the way the HIPAA rules work. Different policies may apply to other CHI programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information
The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you. Further, the Plan may use your health information to contact you to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you. For example, if you are diagnosed or treated for conditions related to high- blood pressure, we may contact you to inform you of available treatment options for that medical condition and where you could access a health care provider to ensure your health care is being properly managed.

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For

example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Note that such programs and activities may be provided by and/or be administered through organizations or entities that are affiliated with CHI, such as Clinically Integrated Network (CIN), if such organization or entity has entered into an agreement to provide such services to the Plan. Such affiliated organizations and entities may use and disclose your health information received from the Plan; however, they are only permitted to use health information disclosed to it for the purposes of providing the services for which they were retained by the Plan, and as described in this Notice. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses private health information (PHI) for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information

The Plan, or its health insurer or CIN, may disclose your health information without your written authorization to CHI for plan administration purposes. CHI may need your health information to administer benefits under the Plan. CHI agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The CHI benefits team within Human Resources is the only CHI employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and CHI, as allowed under the HIPAA rules:

- The Plan, or its insurer or CIN, may disclose "summary health information" to CHI, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or CIN, may disclose to CHI information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that CHI cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by CHI from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

State law may further limit the permissible ways the Plans use or disclose your health information. If an applicable state law imposes stricter restrictions on the Plans, we will comply with that state law.

Other allowable uses or disclosures of your health information
In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule
Business Associates	Disclosures to the Plan's third-party business associates (e.g., a health insurance broker/consultant, wellness coordinator, claims billing organization, etc.) that perform activities or services on behalf of the Plan. Each business associate must agree in writing to protect the confidentiality of your medical information.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. Certain types of medical information have additional protection under state or federal law. For instance, information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, we are required to get your permission before disclosing it to others in many circumstances. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear,

conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete
With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below. You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time. The Catholic Health Initiative Notice of Health Information Privacy Practices is available to you upon your request and may be obtained by writing to:

Catholic Health Initiatives
Attn: HR Operations
3900 Olympic Boulevard, Suite 400
Erlanger, KY 41018-1099

You also may obtain a copy of this notice online by visiting the *well-being* pages found on InsideCHI at **http://home.catholichealth.net/wellbeing**.

Right to Receive Notice of a Breach
You have the right to be notified in writing following a breach of your health information that is not secured in accordance with certain security standards.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice either through mail to your home address on file or online by visiting the *well-being* pages found on InsideCHI at**http://home.catholichealth.net/wellbeing**.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of the U.S. Department of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, please visit the following website to file a complaint online or to obtain a Health Information Privacy Complaint form that can be printed and mailed to the regional Office for Civil Rights, Department of Health & Human Services.

www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Contact
For more information on the Plan's privacy policies or your rights under HIPAA, contact*:*

Director Corporate Responsibility Resources
Privacy Officer
Catholic Health Initiatives
188 Inverness Drive West, Suite 800
Englewood CO 80112

Additional contacts

The following is a list of keypersons or offices you may need to contact to exercise your rights under the HIPAA privacy rule for different benefit plans offered by CHI:

	Restricted disclosures	Confidential communications	Access to or copies of your health information	Amendment of your health information	Accounting of disclosures
Medical Plan – Blue Cross Blue Shield of Illinois	Director, Privacy Office Blue Cross Blue Shield of Illinois P.O. Box 804836 Chicago, IL 60680-4110 Phone: 877-361-7594 (or see back of ID card) Website: http//www.bcbsil.com/important_info/hipaa.html				
Medical Plan – Anthem (CHI Saint Joseph Health & KentuckyOne Health)	Privacy Office OH0101-C300 4361 Irwin Simpson Road Mason, OH 45040 Phone: Call member services on the back of your ID card Email WellPoint's Privacy Office: Privacy.Office@WellPoint.com				
Medical Plan – Wellmark (Mercy Iowa)	Wellmark, Inc. Privacy Office, Station 5W590 1331 Grand Avenue Des Moines IA 50309-2901 Phone: 877-610-6395 Email: privacyoffice@wellmark.com Website: www.wellmark.com				
Medical Plan – Blue Cross Blue Shield of South Carolina (CHI Health)	Privacy Office Blue Cross Blue Shield of South Carolina I-20 East at Alpine Road (AC-200) Columbia, SC, 29219 Phone: 803-264-7258				
Medical Plan – Cigna (Texas)	Privacy Office Cigna Medical Group CIGNA HealthCare of Arizona 25500 N. Norterra Dr. Phoenix, AZ 85085 Phone: 602-906-2800H				
Medical Plan – QualChoice Health Plan Services, Inc. (Arkansas)	QualChoice Health Plan Services, Inc. ATTN: Privacy Official P.O. Box 25610 Little Rock, AR 72221 Phone: 501-228-7111, ext. 5126				
Medical Plan – Zenith (Highline SEIU)	Zenith American Solutions Attn: Tonya Osborne 11724 NE 195th Street #300 Bothell, WA 98011 P: 206-284-4828 VoIP 474828 C: 206-200-6731 tosborne@zenith-american.com				
Prescription Drug Plan – Caremark	CVS Caremark Privacy Office - Investigations & Incident Response team CVS Caremark P.O. Box 52072 Phoenix, AZ 85072-2072				
Dental Plan – MetLife	MetLife Privacy Office P. O. Box 489 Warwick, RI 02887-9954 privacy@metlife.com				

Vision Plan – EyeMed	Privacy Office EyeMed Vision Care, LLC 4000 Luxottica Place Mason, Ohio 45040 Phone: 513-765-4321 Email: privacyoffice@eyemedvisioncare.com Website: www.eyemedvisioncare.com
Employee Assistance Program (EAP) – Beacon Health Options	Phone: Call member services number 877-679-3819
Health Account Administrator – HealthEquity	Phone: Call member services number 866-212-4634
Wellness Plan – Virgin Pulse	The Virgin Pulse Data Protection Officer Virgin Pulse 75 Fountain Street, Suite 310 Providence, RI 02902 Email: privacyofficer@virginpulse.com

Important Plan Information

Plan Sponsor

Catholic Health Initiatives
3900 Olympic Boulevard, Suite 400
Erlanger, KY 41018-1099

Employer Identification Number

47-0617373

Plan Administrator

Catholic Health Initiatives
3900 Olympic Boulevard, Suite 400
Erlanger, KY 41018-1099

Plan Administrator's Authority
The Plan Administrator shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right and power to interpret the Plan and to decide all matters arising under the Plan, including eligibility for Benefits and the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator with respect to any matter relating to the administration of the Plan shall be conclusive and binding on all persons.

The Plan Administrator shall have the following additional powers and duties:

- To require any person to furnish such reasonable information as it may request for the proper administration of the Plan as a condition to receiving any Benefits under the Plan;
- To make and enforce such rules and regulations and prescribe the use of such forms as it shall deem necessary for the efficient administration of the Plan;
- To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan;
- To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, and to provide a full and fair review to any Participant whose Claim for Benefits has been denied in whole or in part;
- To designate other persons to carry out any duty or power which would otherwise be a responsibility of the Plan Administrator under the terms of the Plan; and
- To interpret Plan terms and provisions.

Delegation by the Plan Administrator
The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the administration of Claims or other operations of the Plan. The Plan Administrator and any person to whom any duty or power in connection with the operation of the Plan is delegated may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Employees who are actuaries or accountants), consultant (internal medical director, ombudsman with clinical background, etc.), third party administration service Provider, legal counsel, or other Specialist.

Payment of Administrative Expenses
All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third party administrative service Provider, actuary, consultant, accountant, Specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer.

Funding Policy
The Employer shall fund this Plan out of its general assets. However, the Employer shall also have the right to, in the future, enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type which may become payable under any such insurance contract, to the extent allocable to contributions made by the Employer, shall not be assets of the Plan but shall be the property of and shall be retained by the Employer.

Type of Plan

Welfare Benefit Plan

Plan Number

513

Type of Plan Administration

Employer Administered

Claim Administration

Claims for **medical** Benefits should be directed to:

Blue Cross Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

Claims for the **Health Savings Account** should be directed to:

HealthEquity, Inc.
15 W. Scenic Pointe Dr., Suite 400
Draper, UT 84020

Agent for Service of Legal Process

General Counsel for Catholic Health Initiatives
1999 Broadway
Suite 2605
Denver, CO 80202

Eligibility
Varies by Market-Based Organization or facility

Minimum Maternity Benefits
Group health plans and health insurance issuers offering group insurance coverage, generally may not, under Federal law restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of the above periods.

Loss of Benefits
The provisions regarding termination of coverage and limitations and exclusions of Benefits that may result in reduction or loss of Benefits are explained in this Summary Plan Description.

Contributions
Varies by Market-Based Organization or facility

Funding Arrangements
General assets

Plan Year
The twelve-month period from January 1 to December 31. Your individual Benefit Plan Year may be different depending on your MBO or facility. (See definition of Benefit Plan Year.)

Future of the Plan
Although Catholic Health Initiatives intends to continue the Plan indefinitely, Catholic Health Initiatives reserves the right to amend or end the Plan at any time for any reason. Changes may be made retroactively, if necessary, to qualify or maintain the Benefits under the Internal Revenue Code or the Employee Retirement Income Security Act of 1974 (ERISA). If the plan is amended or ends, you and other active members may not receive Benefits as described in this booklet. However, you may be entitled to receive different Benefits, or Benefits under different conditions. In no event will you become entitled to any vested rights under this Plan.

Statement of ERISA Rights
As a Participant in the Catholic Health Initiatives Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to the following rights:

Receive Information about Your Plan and Benefits

You may examine, free of charge, all documents governing the Plan including insurance contracts, collective bargaining agreements and the latest annual report (Form 5500 Series). These documents are available at the Plan Administrator's office. The annual report also is filed with the U.S. Department of Labor and is available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain copies of all documents governing the operation of the Plan, including updated Summary Plan Descriptions by writing to the Plan Administrator. .

You may also receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
You may continue health care coverage for yourself, your Spouse, or your Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description for the rules governing your COBRA continuation coverage rights.

If you have Creditable Coverage from another plan, you will receive a Certificate of Creditable Coverage that helps to reduce or eliminate exclusionary periods of coverage for Pre-Existing Conditions under your new group health plan. You will be provided a Certificate of Creditable Coverage, free of charge, from Blue Cross Blue Shield:

- When you lose coverage under the plan
- When you become entitled to elect COBRA continuation coverage, or
- When your COBRA continuation coverage ends.

You may also request a Certificate of Creditable Coverage before your coverage ends, or for up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for operating the plan. These people are called "fiduciaries" of the plan. They have a duty to act prudently and in the interest of you and other plan Participants and beneficiaries.

No one, including your Employer or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a Benefit to which you are otherwise entitled or from exercising your rights under ERISA.

Enforcement of Your Rights
If your Claim for a Benefit is denied or ignored, in whole or in part, the Plan Administrator must give you a written explanation of the reason for the denial, and you can obtain copies of documents relating to the decision, without charge. You also have the right to have the Plan Administrator review and reconsider your Claim, all within certain defined time schedules.

Under ERISA, there are steps you can take to ensure the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a

federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If your Claim for Benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. You may also file suit in a federal court if you disagree with a decision, or the lack of a decision, concerning the qualified status of a domestic relations order or medical Child support order. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your Claim is frivolous), it may order you to pay these costs and fees.

Assistance with Your Questions
If you have any questions about this plan, you should contact the CHI Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or contact the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Glossary of Terms

The definitions in this section are terms that are written in capital letters and are used in various sections throughout this Summary Plan Description and have a specific meaning when applied to your health care coverage. When you come across these terms while reading this SPD, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your Benefits. If a term within a definition begins with a capital letter, it means that the term is also defined in these definitions. All definitions have been arranged in alphabetical order. A term that appears in only one section may be defined within that section rather than within this *Glossary of Terms.*

Accident or Accidental Injury…means an accidental bodily injury that is not related to any Illness.

Acupuncture…means the technique of passing long, thin needles through the skin to specific points on the body for treatment of certain Conditions.

Acupuncturist…means a duly licensed acupuncturist.

Admission…means formal acceptance as a patient to a Hospital or other covered facility for a health Condition.

Affordable Care Act (ACA) Preventive Care Drugs…means certain preventive care drugs, as defined by the United States Preventive Services Task Force which are covered 100 percent by the Medical Plan, when prescribed by a physician:

- Aspirin – limited to persons age 45 through 79 years
- Bowel Preparation for Colonoscopy Screening – limited to persons age 49 to 76 years
- Fluoride – limited to persons through the age of 5 years
- Folic Acid – limited to females through the age of 55 years
- Iron – limited to persons less than 1 year of age
- Vitamin D – limited to persons 65 or older

Ambulance…means any licensed land, air, or water vehicle designated, constructed, or equipped for and used for transporting persons in need of medical or surgical attention.

Ambulance Transportation…means local transportation in a specially-equipped certified vehicle from your home, scene of Accident or medical Emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility, or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary services.

Ambulatory Surgical Facility…means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

Anesthesia Services…means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

Annual Enrollment…means the period specified by CHI during which you may elect or change coverage for you and your eligible Dependents.

Applied Behavior Analysis Therapy…means therapy used to improve or change specific behaviors. Applied Behavior Analysis therapy focuses on the principles that explain how learning takes place. Positive reinforcement is one such principle. When a behavior is followed by some sort of reward, the behavior is more likely to be repeated. Applied behavior analysis is the use of techniques and principles to bring about meaningful and positive change in behavior.

Benefit Year…means the period in which your Deductibles, Coinsurance maximums and other Benefit maximums accrue. When you first enroll in the Catholic Health Initiatives (CHI) Medical Plan, your first Benefit Year begins on your Coverage Date and ends on December 31 of that year. On subsequent years, your Benefit Year will be the 12-month period from January 1 to December 31.

Benefits…mean Medically Necessary Covered Services or Supplies that qualify for payment under this Plan.

Billed Amount…means the amount that a Provider bills for a service or supply, or the retail price that a Pharmacy charges for a Prescription Drug, whether or not it is covered under this Plan.

Birth Center…means a duly licensed facility, institution or place where births are planned to occur following a normal, uncomplicated, low-risk pregnancy.

Brand Name Drug…means a drug item which is under the patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies.

Breach…means the unauthorized acquisition, access, use, or disclosure of Unsecured PHI which compromises the security or privacy of such information. For purposes of this definition, "compromises the security or privacy of such information" means poses a significant risk of financial, reputational, or other harm to the individual who is the subject of the PHI. A use or disclosure of a Limited Data Set, that also excludes date of birth and zip code, does not compromise the security and privacy of PHI. Breach excludes:

- Any unintentional acquisition, access, or use of PHI by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by HIPAA.
- Any inadvertent disclosure by a person who is authorized to access PHI at a Covered Entity or Business Associate to another person authorized to access PHI at the same Covered Entity or Business Associate, or Organized Health Care Arrangement in which the Covered Entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.
- A disclosure of PHI where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Business Associate…means any third-party, other than the Plan Sponsor or Plan Sponsor personnel, who receives, uses, or discloses Protected Health Information in connection with the performance of an administrative function on behalf of the Plan or the Organized Health care Arrangement, or in connection with the provision of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or on behalf of the Plan or the Organized Health Care Arrangement, within the meaning of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, 21 CFR Parts 160 and 164 ("HHS Reg."), §160.103.

Catholic Health Initiatives or **CHI**…means Catholic Health Initiatives and its Market-Based Organizations (MBOs).

CHI Facility…means a Hospital or other health care facility which is fully or partially owned by Catholic Health Initiatives (CHI).

Certificate of Credible Coverage…means a certificate disclosing information relating to your Credible Coverage under a health care Benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

Certified Clinical Nurse Specialist…means a duly licensed certified clinical nurse Specialist.

Certified Nurse-Midwife…means a duly licensed certified nurse-midwife.

Certified Nurse Practitioner…means a duly licensed certified nurse practitioner.

Certified Registered Nurse Anesthetist or CRNA…means a duly licensed certified nurse anesthetist.

Chemical Dependency…means substance abuse or dependence on drugs and/or alcohol, including abuse of Prescription Drugs.

Chemotherapy…means the treatment of malignant Conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Child…means:

- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an Eligible Person by birth, marriage, legal adoption, or placement for adoption who is under the age of 26; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an Eligible Person by birth, marriage, legal adoption, or placement for adoption who is under the age of 26 for whom the eligible Person is required by law to provide health coverage; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, under the age of 26 of an eligible Legally Domiciled Adult; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, under the age of 26 who resides primarily in the Eligible Person's household and for whom the Eligible Person is the Legal Guardian, such as a court approved foster child; or
- A dependent (within the meaning of Code § 105(b)) unmarried child of the Eligible Person by birth, marriage, legal adoption, or placement for adoption who is age 26 or over, who is

dependent upon the Eligible Person for support and maintenance because of a continuous developmental or physical disability that began prior to the date the dependent attained age 26 and:

- The disabled dependent was covered by this Plan or other group medical insurance coverage as a disabled dependent prior to reaching age 26.
- If enrolling for the first time, the disabled dependent who is 26 years of age or older of a newly Eligible Person may be enrolled for coverage if the Eligible Person enrolls during the initial eligibility period and provides proof that the dependent satisfies the foregoing requirements within 31 days of the initial date of eligibility.
- The Plan may request documentation of the dependent's continued disability on an annual basis. The disabled dependent shall be eligible for coverage so long as the dependent continues to be disabled, unless coverage otherwise terminates under the Plan.
- The disabled dependent must be continuously covered under the Plan in order to maintain eligibility.

Chiropractor…means a duly licensed chiropractor.

Claim…means notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Billed Amount, and any other information which the Claims Administrator may request in connection with services rendered to you.

Claims Administrator…means Blue Cross Blue Shield of Illinois for medical claims and CVS/Caremark for Prescription Drug claims.

Claim Payment…means the Benefit payment calculated by the Claims Administrator, after submission of a Claim, in accordance with the Benefits described in this SPD. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

Clinical Laboratory…means a duly licensed clinical laboratory.

Clinical Professional Counselor…means a duly licensed clinical professional counselor.

Clinical Social Worker…means a duly licensed clinical social worker.

Clinically Integrated Network (CIN)… means a network of providers, facilities and ancillary services collaborating to improve the health of their patients. For purposes of this Summary Plan Description, the following local CINs are considered an Enhanced network: Rainier Health Network

COBRA…means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an Employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

Coinsurance…means that you and the Plan share a percentage the Eligible Charge.

Condition…means any disease, Illness, Accident or Accidental Injury, bodily dysfunction, pregnancy, Substance Abuse disorder, or Illness Affecting Mental Health.

Copayment or Copay…means a specified dollar amount that you are required to pay towards a Covered Service.

Coverage Date…means the date on which your coverage under the Catholic Health Initiatives (CHI) Medical Plan begins.

Covered Entity…means a health plan, health care clearinghouse, or a health care Provider who transmits Protected Health Information in electronic form.

Covered Provider…means a Provider covered under this Plan.

Covered Service or Covered Services and Supplies…means a service and/or supply specified in this SPD for which Benefits will be provided.

Credible Coverage…means coverage you had under any of the following:

- A group health plan;
- Health insurance coverage for medical care under any Hospital or medical service policy plan, Hospital, or medical service plan contract, or HMO contract offered by a health insurance insurer;
- Medicare (Parts A or B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act);
- Medical care for members and certain former members of the uniformed services and their Dependents;
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health Benefits risk pool;
- A health plan offered under the Federal Employees' Health Benefits Program;
- A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country;
- A health plan under Section 5(e) of the Peace Corps Act; or
- State Children's Health Insurance Program (Title XXI of the Social Security Act).

Custodial Care Service…means any services primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your Condition. Custodial Care Services also means those services that do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressing, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.). Custodial Care Services also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvements by you.

Deductible… means the amount you have to pay before your Catholic Health Initiatives (CHI) Medical Plan Benefits subject to Coinsurance begin. Integrated Core Plan and Integrated Basic Plan exceptions to the deductible are preventive care services, office visits, coinsurance amounts, CHI

Facility charges and Prescription Drugs. Integrated HDHP/HSA Plan exceptions to the deductible are preventive care services.

Dentist…means a duly licensed Dentist.

Dependent…means your Spouse, an eligible Legally Domiciled Adult and/or Child(ren) as defined in this section of the Summary Plan Description. Only one non-child Dependent can be enrolled.

Diabetes Educator…means a duly licensed person who is legally certified to supervise diabetes Outpatient self-management training and educational services. These services are designed to teach diabetics self-management skills and lifestyle changes to effectively manage diabetes and to avoid complications from diabetes.

Diagnostic Service…means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a Condition, disease or Accidental Injury. Such tests include, but are not limited to, x-rays, pathological services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Dialysis Facility…means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

Dietitian…means a duly licensed dietitian.

Drug Utilization Review (DUR)…means a system-based drug Claims review process which alerts Pharmacists and Physicians to important therapeutic issues regarding the use of medication. By alerting Physicians and Pharmacists to issues, DUR reduces risk and improves the quality of care for the patient and reduces unwarranted costs.

Durable Medical Equipment Provider…means a duly licensed durable medical equipment Provider.

Effective Date…means the first day of coverage under CHI's health plan or the first day following the waiting period.

Eligible Charge…means (a) in the case of a Provider other than a Professional Provider which has a written agreement with the Claims Administrator to provide care to you at the time Covered Services are rendered, such Provider's Billed Amount for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with the Claims Administrator to provide care to you at the time Covered Services are rendered, the amount for Covered Services as determined by the Claims Administrator based on the following order:

- The charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by the Claims Administrator, if available,
- The amount that the Center for Medicare & Medicaid Services (CMS) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program, or
- The charge which the particular Hospital or facility usually charges its patients for Covered Services.

Eligible Person…means an Employee of the Employer who meets the eligibility requirements for this coverage, as described in the *Eligibility* section and the *Eligibility Addendum.*

Embedded... means the individual Deductible and Out-of-Pocket Maximums are included in the family Deductible and Out-of-Pocket Maximums. Family members will accumulate deductible and out-of-pocket maximum amounts until they meet the individual limits listed. The remaining family members will accumulate amounts to meet the family limits. No individual of a family will ever meet the entire family limits.

Emergency or Medically Urgent Situation…means an accidental traumatic bodily injury or other medical Condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Prudent Layperson who possesses an average knowledge of health and medicine to:

- Place a patient's health in serious jeopardy, or with respect to a pregnant woman, place the health of the woman or her unborn Child in serious jeopardy;
- Result in serious impairment to the patient's bodily functions;
- Result in serious dysfunction of a bodily organ or body part; or,

In the opinion of a Physician with knowledge of the patient's medical Condition, would subject the patient to sever pain that cannot be managed without the services in question. With respect to a pregnant woman who is having contractions, an Emergency exists where there is inadequate time to affect a safe transfer to another Hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or unborn Child.

Conditions that require immediate Emergency treatment include, but are not limited to the following:

- Heart attacks;
- Strokes;
- Convulsions;
- Serious burns;
- Bone fractures;
- Wounds requiring sutures (stitches);
- Poisoning;
- Severe chest or abdominal pains;
- Loss of consciousness;
- Major depression with significant suicidal intent;
- Psychosis with associated homicidal intent; and
- Manic episode resulting in inability to care for oneself.

In addition, the service provided must be a Covered Service or Supply, and not one that is normally treated on a non-Emergency basis.

Emergency Accident Care…means the initial Outpatient treatment of accidental injuries which a Prudent Layperson would consider an Emergency including related Diagnostic Services.

Emergency Medical Care…means services provided for the initial Outpatient treatment, including related Diagnostic Services, for a medical Condition, which a Prudent Layperson would consider an Emergency and would reasonably require you to seek immediate medical aid.

Examples of Emergency Medical Conditions are: severe chest pains, convulsions, or persistent severe abdominal pains.

Employee…means an individual employed by the Employer who meets the following requirements:

- Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer, and
- Such individual is determined by the Employer to be an Employee, for purposes of the Employer's payroll records. "Employee" does not include a "Leased Employee," as defined in Code Section 414(n)(2). Only individuals who are paid as Employees from the Employer's payroll and are treated by the Employer as Employees will be considered Employees for purposes of the Plan. Any individual who is treated as an independent contractor by the Employer is not an Employee. Also, an individual who renders services to the Employer pursuant to an agreement between the Employer and a leasing organization, temporary employment agency or any other organization is not an Employee. Any individual who is retroactively or in any other way held or found to be a "statutory" or "common-law" Employee of the Employer will not be eligible to participate in the Plan for any period he or she was not contemporaneously treated as an Employee by the Employer and considered by the Employer to be an Employee. In addition, such an individual will remain ineligible for participation in the Plan unless the Plan is amended to specifically render the individual eligible for Plan participation.

Employer…means Catholic Health Initiatives ("CHI") and any MBOs or facilities/entities listed in the *Eligibility Addendum*. Where the context requires it, the term CHI will also mean Employer.

Employment Status…means any of the following events that affect the eligibility of you, your Spouse of your Dependent:

- Termination or commencement of employment with CHI;
- Strike or lockout;
- Commencement of or return from an unpaid leave of absence; and
- Change in worksite.

ERISA…means the Employee Retirement Income Security Act of 1974. ERISA applies to health and welfare plans, as well as retirement plans.

Facility Charge…means charges billed for by a CHI Facility on a universal billing "UB" form. The Facility Charge does not include any charges billed for separately by a Physician or other Provider.

Family Coverage… means coverage for you and your enrolled Dependents under this Plan. For purposes of this SPD Family Coverage will mean Employee/Child(ren), Employee/Spouse or Legally Domiciled Adult, or Employee/Spouse or Legally Domiciled Adult/Child(ren) coverage.

Financial Responsibility…means the degree of financial support sufficient to Claim and eligible Dependent as an exemption of the Eligible Person's federal income tax return.

Formulary…means a listing of preferred Brand-Named Drugs as determined by a committee or Pharmacists and Physicians based on safety, clinical efficacy, and cost of therapy.

Generic Drug…means drug products manufactured and distributed after the patent of the innovator brand-name drug has expired. The Generic Drug must have the same active ingredient, strength, and dosage form as its brand-name counterpart.

Group Coverage…means a plan whose members share a common relationship, such as employment or membership.

HDHP/HSA Covered Preventive Drugs...means certain approved drugs that will not be subject to the deductible on the Integrated HDHP/HSA. The drugs will, however, still have the appropriate coinsurance for the tier of the specific drug. These drugs can be found on the CVS/Caremark HDHP Plan Preventive Drug List. The list is located on the "Pharmacy Plan" page under the Benefit tab on the *well-being* pages found on InsideCHI at **http://home.catholichealth.net/wellbeing**. You can also check the Formulary Drug List for other medications that are covered on the plan. The cost of these drugs will apply to your deductible, and then coinsurance applies. See Pharmacy Coverage of Benefits for additional information.

Health Savings Account (HSA) …means an account funded by you and possibly your employer that can be used to cover the cost of covered services, including prescription drugs, up to the IRS annual limit or the accrued amount in your account.

HIPAA…means the Health Insurance Portability and accountability Act of 1996.

Home Health Care Program…means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of a registered professional nurse, the services of Physical Therapists, Hospital laboratories, and necessary medical supplies. It does not include Custodial Care Service.

Home Infusion Therapy Provider…means a duly licensed home infusion therapy Provider.

Hospice…means a duly licensed autonomous, centrally administered, nurse-coordinated program providing home, Outpatient, and Inpatient care for a covered Participant who is Terminally Ill and members of the Participant's family. At a Hospice, a team of healthcare Providers assists in providing Palliative Care and support to meet the special needs arising during the final stages of Illness, and during dying and bereavement. This team of Providers includes a doctor and nurse, and may also include a social worker, a clergy member or counselor and volunteers.

Hospice Care Program Provider…means an organization duly licensed to provide Hospice Care Program Services.

Hospice Care Program Service…means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of Hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special Hospice care unit.

Hospital…means a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by Registered Nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged, or similar institutions.

The term Hospital does not include a specialty institution or residential facility, or a U.S. Government Hospital or any other Hospital operated by a governmental unit, unless a charge is made by the Hospital that the patient is legally required to pay without regard to insurance coverage.

Infertility…means the inability to conceive a Child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Illness…means physical sickness or disease, pregnancy, or congenital anomaly.

Illness Affecting Mental Health…means those Illnesses, classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

Independent Clinical Laboratory…means a duly licensed facility where human materials or specimens are examined for the purpose of diagnosis, prevention, or treatment of a Condition.

Individual Coverage…means coverage under the health care plan for yourself.

Injury…means a bodily injury that is not related to any Illness.

In-Network Provider…means a Professional Provider which has a written agreement with the Claims Administrator to provide services to Participants.

Inpatient…means that you are a registered bed patient and are treated as such in a health care facility.

Intensive Care Unit…means a specialized area in a Hospital where an acutely ill patient receives intensive care or treatment. Included in the Hospital's charge for an Intensive Care Unit are the services of specially trained professional staff and nurses, supplies, and the use of any and all equipment and the patient's board. A coronary care unit is also considered an Intensive Care Unit.

Investigational…means procedures, drugs, devices, services and/or supplies which

- Are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency, effectiveness, and/or
- Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and
- Specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

Law Enforcement Official…means an officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, who is empowered by law to:

- Investigate or conduct an official inquiry into a potential violation of law; or
- Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Legal Guardian or Guardianship…means an individual who was appointed as guardian, conservator, loco parentis or similar role for a Child by a court having appropriate jurisdiction over such Child.

Legally Domiciled Adult means an individual over 18 who has, for at least six months, lived in the same principal residence of an employee and remains a member of that employee's household throughout the coverage period; and who either:

- Has an on-going, exclusive and committed relationship with the employee (not a casual roommate or tenant), shares basic living expenses and is financially interdependent with the employee, is neither legally married to anyone else nor legally related to the employee by blood in any way that would prohibit marriage.
- Is the employee's blood adult relative who meets the definition of his or her tax dependent as defined by Section 152 of the Internal Revenue Code during the coverage period and is not considered a Child as defined in this section of the Summary Plan Description.

Legend Drug…means a drug that is approved by the U.S. Food and Drug Administration (FDA) and is required by federal or state law to be dispensed to the public only on prescription of a licensed physician or other licensed provider. Legend drugs are also called prescription drugs.

Level of Coverage…means the medical Plan option selected by the Plan Participant.

Lifetime Maximum…means the maximum amount that this Plan will pay over the course of an Employee or Dependent's lifetime.

Maintenance Occupational, Physical and/or Speech Therapy…means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a Condition will occur.

Marriage and Family Therapist…means a duly licensed marriage and family therapist.

Massage Therapist…means a duly licensed massage therapist.

Massage Therapy…means the treatment for chronic pain by physical means by a Physician, registered professional Physical Therapist Chiropractor, or licensed Massage Therapist. Massage Therapy must be prescribed by a Physician and must be Medically Necessary.

Maternity Service…means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MBO…means a Market-Based Organization or facility of CHI.

Medical Care…means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an Illness or Accidental Injury.

Medically Necessary or Medical Necessity…means that a specific service provided to you is reasonably required, in the reasonable judgment of the Claims Administrator, for the treatment of management of a medical symptom or Condition and that the service provided is the most efficient and economical service which can safely be provided to you. When applied to Hospital Inpatient Services, Medically Necessary means that your medical symptoms or Condition require that the treatment be provided to you as an Inpatient and that treatment cannot safely be provided to you as an Outpatient. Further, Medically Necessary means that Inpatient Hospital care and treatment will not be covered when, in the reasonable judgment of the Claims Administrator, your medical symptoms and Condition no longer necessitate your continued stay in a Hospital. The fact that a Physician or other health care Provider may prescribe, order, recommend, or approve a service or supply does not of itself make such a service Medically Necessary.

Medicare…means the program established by Title XVIII of the Social Security Act (42 U.S.C.§ 395 et seq.).

Medicare Approved or Medicare Participating…means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare Program.

Medicare Secondary Payer or MSP…means those provisions of the Social Security Act set forth in 42 U.S.C.§ 395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain Employers may offer group health care coverage to Medicare-eligible Employees, their Spouses and, in some cases, Dependent Children.

Mental Health Condition…means an Illness Affecting Mental Health.

Mental Health Unit…means a unit established to perform preadmission review and length of stay review for Inpatient and/or Outpatient services for the treatment of Illness Affecting Mental Health and Substance Abuse.

Out-of-Network Provider…means a Hospital, Professional Provider, or facility which does not have a written agreement with the Claims Administrator to provide services to Participants. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services.

Occupational Therapist…means a duly licensed occupational therapist.

Occupational Therapy…means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Optometrist…means a duly licensed optometrist.

Organized Health Care Arrangement…means this Plan and each other health plan maintained by the Plan Sponsor, including the insurers that provide Benefits under any such plan.

Orthotic Provider…means a duly licensed orthotic Provider.

Out-of-Pocket Maximum…means the maximum amount you are required to pay in a Benefit Year for Eligible Medical and Prescription Charges for your Copayments, Coinsurance and Deductible. The Out-of-Pocket Maximum does not include penalties and charges that are ineligible for reimbursement.

Outpatient…means that you are receiving treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an Emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

Outpatient Facility…means a duly licensed facility other than a doctor's, physical therapist's or midwife's office that provides Outpatient services for treatment of an Illness or Accident, other than for Illness Affecting Mental Health or Substance Abuse.

Palliative Care…means reduction or abatement of pain and other troubling symptoms through services provided by members of the Hospice team of Providers.

Partial Hospitalization Treatment Program…means a Claims Administrator approved planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Illness Affecting Mental Health or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

Participant or **Plan Participant**…means a person covered under this Plan.

Permitted Disclosures…means any disclosure for purposes of payment, treatment, or health care operations of a plan or its Organized Health Care Arrangement as defined in HHS Reg. §164.501.

Permitted Uses…means any payment, treatment, or health care operation of the Plan or its Organized Health Care Arrangement as defined in HHS Reg. §164.501.

Pharmacist…means a duly licensed Pharmacist.

Pharmacy…means any licensed establishment in which the profession of Pharmacy is practiced.

Physical Therapist…means a duly licensed physical therapist.

Physical Therapy…means the treatment of a disease, injury, or Condition by physical means by a Physician or a registered profession physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician…means a Physician duly licensed to practice medicine in all of its branches.

Physician Assistant…means a duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist, or Podiatrist and billing under such Provider.

Plan…means the Medical Plan.

Plan Administrator or Plan Sponsor…means CHI.

Plan Administration Functions…means administration functions performed by Plan Sponsor personnel on behalf of a plan and excludes functions performed by the Plan Sponsor in connection with any other Benefit or Benefit plan of the Plan Sponsor.

Podiatrist…means a duly licensed podiatrist.

Post-Service Claim…means any claim for a Benefit under the Medical Plan that is not a Pre-Service Claim.

Prescription Drug…means a drug that bears the legend, "Caution, Federal Law prohibits dispensing without a prescription and meets the following criteria:

- Prescribed by a Provider who is legally authorized to prescribe;
- Dispensed by a recognized licensed retail Pharmacy, a contracting specialty Pharmacy, or through the mail-order drug program; and
- Is Medically Necessary for your Illness or Accidental Injury or is approved for Preventive or Wellness Care.

Covered drugs are limited to those taken orally, absorbed through the skin, and certain injected Prescription Drugs. Devices and implants are not considered to be Prescription Drugs.

Pre-Service Claim…means any Claim for a Benefit under the Medical Plan which is made in advance of obtaining the requested services or supplies.

Preventive Care or Preventive Care Services…means history and physical examinations, routine laboratory services, immunizations, routine history and gynecological exams, and well-child care, including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination, as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Primary Care Physician…means a general practitioner, family practitioner (family practice Physician), doctor of internal medicine (internist), pediatrician, doctor of obstetrics/gynecology, nurse practitioner, Registered Nurse, nurse-midwife, or Physician Assistant.

Prior Authorization…means the process of obtaining approval as to appropriateness of a medication before it is actually dispensed and utilized.

Privacy Officer…means the CHI Privacy Officer.

Private Duty Nursing Service…means Skilled Nursing Service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.), or a licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

Prosthetic Provider…means a duly licensed prosthetic Provider.

Protected Health Information…means information including demographic information collected from an individual, that is created or received by a plan and that is transmitted or maintained in any medium (including verbally) that

- Relates to the past, present, or future physical or mental health Condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- That identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information shall not include information that is de-identified in accordance with HHS Reg. §164.514(a). Protected Health Information also includes genetic information. Genetic information is information about an individual's family members, and the manifestation of a disease or disorder in the individual's family members. Family members include dependents and any other individual who is a first-, second-, third-, or fourth-degree relative
of the individual or the individual's Dependents.

Provider or Professional Provider…means a duly licensed provider designated by the Medical Plan to render Covered Services or Supplies to you as a Provider. For the services of these Providers to be covered, the service must meet the definition of Covered Services or Supplies, and the Provider must be providing the services or supplies within the scope of his or her license or certification.

Provider does not include athletic trainers; boarding houses; camps or schools; convalescent facilities, institutions for chronic care, personal care, residential or domiciliary care, or homes for the aged; dental assistants and dental hygienists; education or training programs; halfway houses; health resorts; health spas; hypnotists; homeopathic medical Providers, hotels, motels and other lodging; priests, and other religious affiliates; naturopaths; opticians; orthodontists; residential treatment centers; residents, interns, or other Employees of Hospitals or Skilled Nursing Facilities who bill for their services and are not listed as Covered Providers; rest homes; sanitariums; and other non-traditional medical Providers; transportation other than by Ambulance; and any facilities or Providers not specifically mentioned within this SPD that are not specifically designated by CHI to be eligible providers.

Psychologist…means a Registered Clinical Psychologist.

Prudent Layperson…means a person who possesses an average knowledge of health and medicine.

Qualified Status Change…means a life event such as:

- Marriage;
- Divorce, legal separation or annulment;
- Birth of a Child, adoption, placement for adoption, or Legal Guardianship;
- Change of a Child's eligibility status due to reaching the maximum age;
- Loss of Legal Guardianship;
- Death of a Child or Spouse;
- Changes in your work status that affect eligibility for Benefits;
- Changes in a Spouses work status affecting eligibility for Benefits;
- Gaining or losing eligibility for another plan such as expiration of COBRA coverage from another Employer's plan, gaining or losing eligibility for Medicare or Medicaid;
- Gaining or losing eligibility for the Medicaid or state Children's Health Insurance Program (CHIP); or

- Qualified Medical Child Support Order requiring you or your Spouse to provide health coverage for a Dependent.

Since this Plan is funded in part by pre-tax Employee contributions, it is governed by IRS regulations that indicate that a Participant may only change his or her Benefit Plan elections during Annual Enrollment unless there is a Qualified Status Change, and that the change elected must be consistent with the Qualified Status Change. All changes must be made within 31 days of the Qualified Status Change except changes in elections resulting from birth, adoption, gaining legal custody of a dependent child, or gaining or losing eligibility for Medicaid or state CHIP must be made within 60 days.

Qualified Exigency…means, as defined by the Department of Labor for purposes of the Family and Medical Leave Act, an Emergency arising out of one of the following categories:

- Short-notice deployment;
- Military events and related activities;
- Childcare and school activities;
- Financial and legal arrangements;
- Counseling;
- Rest and Recuperation;
- Post-deployment activities; and
- Additional activities not encompassed in the other categories but agreed to by the Employer and Employee.

Qualified Medical Child Support Order or QMCSO…means a medical Child support order, qualifying under ERISA and approved by the Plan Administrator, that provides for health care coverage and allocation of responsibility for the payment of costs for health care coverage for a natural or adopted Child of an Employee or Spouse.

Registered Dietitian…means a duly licensed registered dietitian.

Registered Nurse (RN) or Licensed Practical Nurse (LPN)…means a person duly licensed to practice nursing.

Registered Surgical Assistant…means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified, or Registered Nurse first assistant.

Related Professional Services…means services that are provided at the same time as the office visit (e.g., lab work done while in the doctor's office).

Renal Dialysis Treatment…means one unit of service, including the equipment, supplies, and administrative services which are customarily considered a necessary to perform the dialysis process.

Residential Treatment Facilities…means a duly licensed facility that treats an intermediate level of substance abuse on both an inpatient and outpatient basis. It provides a detailed regimen that includes full-time residence and full-time participation by the patient within a residential treatment facility which provides room and board, evaluation and diagnosis, counseling, referral and orientation to specialized community resources.

Skilled Nursing Facility…means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Service…means those services provided by a Registered Nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Specialist…means any Physician other than a Primary Care Physician who is classified as a Specialist by the American Boards of Medical Specialties; or who is designated by the Plan as a Specialist Physician.

Specialty Drug…means drugs that are typically used for treating or managing chronic Illnesses. These drugs often require special handling (e.g., refrigeration) and administration. Some Specialty Drugs may be taken orally, but others may require administration by injection, infusion, or inhalation. Specialty Drugs may not be available from a retail Pharmacy.

Speech Therapist…means a duly licensed Speech Therapist.

Speech Therapy…means the treatment for the correction of a speech impairment resulting from disease trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

Spouse…means a person who is legally married under the laws of the state where the marriage was celebrated to an employee who is participating in the health care benefits offered by CHI, regardless of where that couple currently resides.

Step Therapy or Step Therapy Program…means the program which requires you to first try one or more specified drugs to treat a particular Condition before the Plan will cover another (usually more expensive) drug that your Physician may have prescribed.

Substance Abuse…means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers, and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

Substance Abuse Rehabilitation Treatment…means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or Psychologist, court-ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation, or learning disabilities, care in lieu of detention or correctional placement or family retreats.

Substance Abuse Treatment Facility…means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses, or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Summary Health Information…means information that summarizes the Claims history, Claims expense or types of Claims experience by an individual for whom Benefits are or were provided under the Plan, provided that individual identifying information has been deleted.

Summary Plan Description or SPD…means this booklet which describes the features of this Benefit Plan.

Surgery…means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claims Administrator.

Suspected Breach…means the suspected unauthorized acquisition, access, use, or disclosure of Unsecured PHI.

Temporomandibular Joint Dysfunction (TMJ) and Related Disorders…means jaw joint Conditions including temporomandibular joint disorders and craniomandibular disorders, and all other Conditions of the joint linking the jaw bone and skull and the complex muscles, nerves, and other tissues relating to that joint.

Terminally Ill…means a person has a life expectancy of six months or less because of a chronic, progressive Illness that is incurable according to the person's doctor.

Unsecured PHI…means Personal Health Information (PHI) that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of one of the following technologies or methodologies:

- Encryption: Electronic PHI has been encrypted by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. (See encryption processes identified by HHS as having been tested by the National Institute of Standards and Technology (NIST) and judged to meet this standard.)
- Destruction: The media on which the PHI is stored or recorded has been destroyed in one of the following ways:
  - Paper, film, or other hard copy media have been destroyed such that PHI cannot be read or otherwise cannot be reconstructed.
  - Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization, such that the PHI cannot be retrieved.
- Any other technology or methodology specified by the Secretary of Health and Human Services for this purpose.

Urgent Care Facility…means a duly licensed Urgent Care Facility.

Urgent Pre-Service Claim or Appeal…means a review request that is expedited due to life changing or life-threatening circumstances for pre-service approval. The review takes 72 hours. You may be eligible for an expedited external review if you have a medical condition in which the normal timeframe for a standard external review or an expedited internal appeal could:

- Seriously jeopardize your life or health; or
- Your request involves an admission or continued stay, or health care service for which you received emergency services but have not yet been released.

You might also qualify for an expedited appeal if your request involves an experimental or investigation determination and your health care provider certifies in writing that the service/treatment would be significantly less effective if not promptly initiated.

Workforce Member…means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for an entity, is under the direct control of such entity, whether or not they are paid by such entity.

Eligibility Addendum

Initial eligibility requirements and effective date of coverage for employees vary by Market-Based Organization (MBO). All other eligibility provisions are determined by the Plan Administrator and are consistent across all MBOs and national offices. All MBOs have a Benefit Year beginning on January 1st and ending on December 31st.

Unless otherwise indicated, **Benefits will begin on the first of the month following your waiting period**. Hours listed are per pay period and are the regularly scheduled hours as reflected in the payroll system as the full-time equivalent or FTE. Where an employee holds more than one position with the Employer, the regularly scheduled hours will be added together for purposes of establishing the FTE for the purpose of benefits eligibility. An Employee's FTE will be evaluated and updated periodically throughout the year.

Market-based organization (MBO) or CHI Facility	City	State	Waiting Period	FT Hrs	PT Hrs
CHI National Offices	Various	All	30 days	64	40
Franciscan Health System	Tacoma	WA	30 days	32	n/a
Franciscan Medical Group	Tacoma	WA	30 days	64	40

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Effective January 1, 2019

SER-222

The Honorable Robert J. Bryan

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	NO. 3:20-cv-06145-RJB DECLARATION OF PATRICIA PRITCHARD IN SUPPORT OF PLAINTIFF C.P.'S MOTION FOR CLASS CERTIFICATION

I, Patricia Pritchard, declare under penalty of perjury and in accordance with the laws of the State of Washington and the United States that:

1. I am over the age of 18 and competent to testify to all matters stated herein. All statements are made upon my personal knowledge.

2. I am the mother of C.P., the named plaintiff in the above captioned litigation. He receives coverage of health benefits through the Catholic Health Initiatives Medical Plan as administered by Blue Cross Blue Shield of Illinois ("BCBSIL") due to my employment. C.P. received that health coverage for all times relevant to this litigation.

3. I am familiar with the duties and responsibilities of being a class representative. I am willing to be class representative, along with my husband, on behalf of C.P. and other similarly situated persons in the proposed class. If appointed, we will

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diligently look out for the interests of all class members. I am not aware of any conflict we may have with any class members.

DATED this 23 day of August, 2022, at Bremerton, Washington.

Patricia Pritchard

Patricia Pritchard

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