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 S[redacted] R[redacted]

I, S[redacted] R[redacted], 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 a 12-year-old transgender girl, S.L., who is diagnosed with two separate serious conditions: gender dysphoria and early-onset (precocious) puberty.

3. Although S.L. was assigned male at birth, she has identified as female since she was four years old. S.L. socially transitioned to female around the age of seven. She has legally changed her name and gender to match her identity.

SIRIANNI YOUTZ
SPOONEMORE HAMBURGER PLLC
3101 WESTERN AVENUE, SUITE 350
SEATTLE, WASHINGTON 98121
TEL. (206) 223-0303 FAX (206) 223-0246

4. S.L. is enrolled in a self-funded health plan administered by Blue Cross Blue Shield of Illinois (BCBSIL), through my husband's employment with a non-religious employer headquartered in Illinois.

5. Up until about two years ago, our family, including S.L., received our health coverage through a Blue Cross of Blue Shield of Oregon (BCBSOR) health plan provided through my husband's previous employer. At the time, my daughter was receiving quarterly intramuscular injections of Lupron (in her thigh), a medication covered by BCBSOR, to stop the commencement of puberty. This type of medication is sometimes referred to as a "puberty blocker."

6. When my husband changed employers about two years ago, we switched to the BCBSIL-administered plan furnished through his new employer.

7. After we switched health plans, my daughter S.L. was prescribed Supprelin, an implantable device that delivers puberty-blocking hormones into the patient. Supprelin is a more effective puberty blocker than Lupron (which was only partially effective at blocking S.L.'s early-onset puberty), and its administration does not require the painful, quarterly intramuscular injections that left S.L. limping for days after each injection.

8. On or around February 17 and May 24, 2022, S.L.'s health care providers requested pre-authorization of her puberty blockers - both Lupron and Supprelin. BCBSIL provided notice that each preauthorization was approved. Attached as *Exh. 1,* is a true and correct copy of the notice we received.

9. Despite the pre-authorization, BCBSIL ultimately denied coverage of S.L.'s puberty blockers. Attached as *Exh.* 2, is a true and correct copy of the denial we received.

10. On or around, March 17, 2023, we submitted an internal appeal of the denial of coverage for S.L.'s puberty blockers.

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11. In a letter dated May 19, 2023 addressed to me, BCBSIL informed me that it denied the appeal, upholding the initial decision that "transsexual surgery and related psychiatric care are not covered." The denial letter cites this text from the health plan's "Summary Plan Description and/or benefit booklet:

> According to the "Exclusions- What is Not Covered" section:
>
> Expenses for the following are not covered under your benefit program:
>
> Gender reassignment surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies.

12. The letter also stated that my "internal appeal rights have now been exhausted." Attached as *Exh. 3* is a true and correct copy of the denial of my internal appeal.

13. Sometime in March 2023, I was told by BCBSIL membership services that, had S.L. been diagnosed ***only*** with early-onset puberty (i.e., not gender dysphoria AND early-onset puberty), BCBSIL would have likely covered the puberty blocker.

14. Based on our consultation with S.L. healthcare providers, S.L. may require a new puberty blocker implant by the end of the year as well as gender affirming hormones in the future.

15. The cost of S.L.'s puberty blockers is so high that we cannot afford to pay for these services out of pocket. Indeed, we are presently faced with nearly $200,000 in uncovered medical bills related to BCBSIL's denial of the 2022 puberty blocker and ongoing denials related to her bloodwork to monitor the blocker.

16. BCBSIL has also denied coverage of S.L.'s mental health treatment. We believe the denials are based upon her diagnosis with gender dysphoria.

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17. We anticipate that S.L. will require gender affirming care in the future, possibly including surgery. We want to ensure that BCBSIL does not continue to administer gender affirming care exclusions like that in S.L.'s health plan. S.L. should not continue to suffer discrimination because of her gender identity.

18. I am familiar with the duties and responsibilities of being a named plaintiff/class representative. I have read the class definition as it was proposed by the Plaintiffs and amended by the Court in an Order issued on November 9, 2022, listed as Dkt. No. 113 and as amended in Dkt. No. 143. I am willing to be class representative on behalf of other persons in the class similarly situated to myself or S.L. If appointed, I will diligently look out for the interests of all class members. I am not aware of any conflict I may have with any proposed class members.

19. On behalf of S.L., my husband and I are willing to be named plaintiffs/class representatives if it is helpful to the Plaintiff Class.

DATED this __19th__ day of September, 2023, at ____Portland____, OR.

DocuSigned by:
[redacted]
036DB4A0EA23...
[redacted]

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SPOONEMORE HAMBURGER PLLC
3101 WESTERN AVENUE, SUITE 350
SEATTLE, WASHINGTON 98121
TEL. (206) 223-0303 FAX (206) 223-0246

Exhibit 1

Close

S[redacted] L[redacted]

May 24, 2022 - May 24, 2023

Overall Status: Approved

Provider: Megan Jacobs

Request ID: U22048CDGF

Feedback

1 Service:

C11981

Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)

1 **Visits Allowed**

Status:
Approved
May 24, 2022 - May 24, 2023

Close

S[redacted] L[redacted]

Feb 17, 2022 - May 24, 2022

Overall Status: Approved

Provider: Kara Connelly

Request ID: U22048CCON

Feedback

1 Service:

C96372

Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

2 **Visits Allowed**

Status:
Approved
Feb 17, 2022 - May 24, 2022

Exhibit 2

BlueCross BlueShield of Illinois
PO Box 7344
Chicago, IL 60680 7344

EXPLANATION OF BENEFITS

Log into **Blue Access for Members℠** at **bcbsil.com**
- View plan and claim details
- Contact us through our secure Message Center
- Sign up for digital health plan info
- Search for health care providers

Text* **BCBSILAPP** to **33633** to download the mobile app.

Have questions about this EOB? Customer Advocates are here to help! **1-800-828-3116**

R C. L
PORTLAND, OR

SUBSCRIBER INFORMATION

PREMIUM ACTIVES
Member ID#: **XXXXXXX3088** Group #: **000P17192**

Dear R C. L,

An Explanation of Benefits (EOB) is a statement showing how claims were processed. **This is not a bill.** Your provider(s) may bill you directly for any amount you may owe. **KEEP FOR YOUR RECORDS.**

HELPFUL INFORMATION

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Health care fraud affects health care costs for all of us. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Illinois, please call our toll-free hotline. All calls are confidential and may be made anonymously. For more information about health care fraud, please go to **bcbsil.com.**

GLOSSARY OF TERMS - **We have described some of the terms used here to help you understand them, but you should make sure to read your benefit plan materials if you have questions.**

Amount Billed: The amount your provider billed for the service(s) rendered.

Amount Covered (Allowed): Discounts, reductions, and amount covered (allowed) reflect the terms of your plan, and in the case of an in-network provider, the savings we have negotiated with your provider. Your deductible, coinsurance and copay are based on the allowed amount and the terms of your plan. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.

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Copay Amount (Also known as Copayment): The set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible: The amount, if any, you must pay before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the deductible is met.

Non-Participating Provider: An out-of-network provider who does not accept rates for services we set to keep your costs down.

Out-of-Pocket Limit (Maximum): Once you pay this amount in deductibles, copayments and coinsurance for covered services, we pay 100% of the allowed amount for covered services for the rest of the benefit period.

Participating Provider: An in-network or out-of-network provider who accepts agreed-upon rates for services.

Your Total Costs: This is the sum of your copay, deductible and coinsurance. It also includes any amounts not covered by your health plan. Amounts that a non-participating provider may bill you are not part of this.

BlueCross BlueShield of Illinois

SUBSCRIBER INFORMATION
PREMIUM ACTIVES
Member ID#: **XXXXXXXX3088** Group #: **000P17192**
Customer Advocates are here to help! **1-800-828-3116**

CLAIM DETAIL (1 of 1)
PATIENT: S[redacted] R. L[redacted]
PROVIDER: MEGAN JACOBS
CLAIM #: 2159551897W0H **DATE PROCESSED:** 07/11/2023

We have reviewed the claim which was previously processed for this patient. The following shows how this claim was adjusted.

Amount Billed	$140,122.91
Discounts and Reductions	- $0.00
Health Plan Responsibility	- $0.00
You may owe your health care provider for these services	**$140,122.91**

			YOUR BENEFITS APPLIED			YOUR RESPONSIBILITY				
Service Description	**Service Dates**	Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	**Your Total Costs**
Surgery	05/24/2022	517.00							(1) 517.00	517.00
Injectable/Oral Med	05/24/2022	139,605.91							(1) 139,605.91	139,605.91
CLAIM TOTALS		**$140,122.91**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$140,122.91**	**$140,122.91**

Notes about amounts under "YOUR BENEFITS APPLIED" and "YOUR RESPONSIBILITY"

(1) Transgender services, including this service, are not covered under the terms of your plan. You may be responsible for the billed charge.

For your up-to-date Medical Spending summary, visit Blue Access for Members℠ on our website, the BCBSIL Mobile App or call the phone number on the back of your ID card.

BlueCross BlueShield of Illinois

IMPORTANT INFORMATION (Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to:
Blue Cross and Blue Shield of Illinois
Claim Review Section
PO Box 2401
Chicago, IL 60690

To file an appeal or if you have questions, please call 800-458-6024 (TTY/TDD: 711), send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members℠ (BAM℠) at bcbsil.com

Authorized Representative

You can name a person to act for you (including an attorney) on your appeal or external review – known as an "authorized representative." To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form.

Standard Appeal

You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:

- A copy of the decision letter or Explanation of Benefits (EOB)
- The reference number or claim number (often found on the decision letter or EOB)

You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your appeal.

What happens next?	We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

Expedited (Urgent) Appeal

You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call us at 800-458-6024 (TTY/TDD: 711) or fax your request to 918-551-2011. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling 800-458-6024.

What happens next?	If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request.

BlueCross BlueShield of Illinois

Your Right to a Standard External (Outside) Review	
You may ask for an external review with an Independent Review Organization (IRO) if your appeal was denied based on any of the reasons below. You may also ask for external review if we failed to give you a timely decision as stated in the Standard Appeal section above, and your claim was denied for one of these reasons: • A decision about the medical need for or the experimental status of a recommended treatment • A condition was considered pre-existing • Your health care coverage was rescinded (see your Benefit Booklet for details) If your case qualifies for external review, an IRO will review your case (including any data you'd like to add), at no cost to you, and make a final decision. To ask for an external review, you'll need to complete the necessary form and submit it to BCBSIL. You may get a form by calling the number on your ID card. Unless your plan says otherwise, you have 4 months from the date you received the decision notice to file your external review request.	
What happens next?	If you qualify for an External Review, an IRO will review your case and mail you its decision within 45 calendar days. That decision is final and binding on BCBSIL and you.

Expedited (Urgent) External Review	
You can ask for this type of review if: • failure to get treatment in the time needed to complete an Expedited Appeal or an External Review would seriously harm your life, health or ability to regain maximum function; • the request is about an admission, availability of care, continued stay or health care service that you received with emergency services, before your discharge from a facility; • the request for treatment is experimental or investigational and your health care provider states in writing that the treatment would be much less effective if not promptly started; or, • we failed to give you a decision within 72 hours of your request for an expedited appeal The IRO that does the expedited external review will decide if the covered person needs to complete the expedited (urgent) appeal process before the Expedited (Urgent) External Review can be started. If you think your case may qualify for an Expedited External Review, call 800-458-6024.	
What happens next?	If you qualify for this type of review, the IRO will give you a decision within 72 hours.

Notice about Provider Appeals
If you used an in-network provider, your provider may be able to file an appeal request for benefits you've been denied. You and your provider may file appeals separately and at the same time. Deadlines for filing appeals or external review requests are not delayed by appeals made by your provider UNLESS you have chosen your provider to act for you as your authorized representative. Choosing your provider to act for you must be done in writing. If your provider is acting on your behalf, then the provider must meet the deadlines you would have to meet to file such requests.

Additional Rights
If you receive your benefits through an employer, you may also have the right to bring an action under Section 502(a) of a law called ERISA. To learn more, call the Employee Benefits Security Administration at 866-444-EBSA (3272).

BlueCross BlueShield of Illinois

Department of Insurance

The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, wish to file a complaint or wish to take up your matter with the IDOI, you may use either address below.

IDOI
320 W. Washington St.
Springfield, Illinois 62767-0001

Review Request: 877-850-4740
Fax: 217-577-8495

IDOI, Office of Consumer Health Insurance
122 S. Michigan Ave .,19th Floor
Chicago, Illinois 60603

Complaints: 877-527-9431
Email: DOI.InfoDesk@illinois.gov

IDOI Web: https://mc.insurance.illinois.gov

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

BlueCross BlueShield of Illinois
PO Box 7344
Chicago, IL 60680 7344

EXPLANATION OF BENEFITS

Log into **Blue Access for Members℠** at **bcbsil.com**
- View plan and claim details
- Contact us through our secure Message Center
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Text* **BCBSILAPP** to **33633** to download the mobile app.

Have questions about this EOB? Customer Advocates are here to help! **1-800-828-3116**

R[redacted] C. L[redacted]
[redacted]
PORTLAND, OR [redacted]

SUBSCRIBER INFORMATION

PREMIUM ACTIVES
Member ID#: **XXXXXXX3088** Group #: **000P17192**

Dear RICHARD C. LANG,

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HELPFUL INFORMATION

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Deductible: The amount, if any, you must pay before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the deductible is met.

Non-Participating Provider: An out-of-network provider who does not accept rates for services we set to keep your costs down.

Out-of-Pocket Limit (Maximum): Once you pay this amount in deductibles, copayments and coinsurance for covered services, we pay 100% of the allowed amount for covered services for the rest of the benefit period.

Participating Provider: An in-network or out-of-network provider who accepts agreed-upon rates for services.

Your Total Costs: This is the sum of your copay, deductible and coinsurance. It also includes any amounts not covered by your health plan. Amounts that a non-participating provider may bill you are not part of this.

BlueCross BlueShield of Illinois

SUBSCRIBER INFORMATION
PREMIUM ACTIVES
Member ID#:**XXXXXXXX3088** Group #: **000P17192**
Customer Advocates are here to help! **1-800-828-3116**

CLAIM DETAIL (1 of 1)
PATIENT: S[redacted] R. L[redacted]
PROVIDER: KARA CONNELLY
CLAIM #: 2104555F0630H **DATE PROCESSED:** 06/30/2023

We have reviewed the claim which was previously processed for this patient. The following shows how this claim was adjusted.

Amount Billed	$33,212.31
Discounts and Reductions	- $0.00
Health Plan Responsibility	- $0.00
You may owe your health care provider for these services	**$33,212.31**

			YOUR BENEFITS APPLIED			YOUR RESPONSIBILITY				
Service Description	**Service Dates**	Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	**Your Total Costs**
Injectable/Oral Med	03/30/2022	33,053.31							(1) 33,053.31	33,053.31
Injectable/Oral Med	03/30/2022	159.00							(1) 159.00	159.00
CLAIM TOTALS		**$33,212.31**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$33,212.31**	**$33,212.31**

Notes about amounts under "YOUR BENEFITS APPLIED" and "YOUR RESPONSIBILITY"

(1) Transgender services, including this service, are not covered under the terms of your plan. You may be responsible for the billed charge.

For your up-to-date Medical Spending summary, visit Blue Access for Members℠ on our website, the BCBSIL Mobile App or call the phone number on the back of your ID card.

BlueCross BlueShield of Illinois

IMPORTANT INFORMATION (Retain for your records)

If we have denied your claim for benefits, in whole or in part, for a treatment or service, rescinded (see your Benefit Booklet for details) your coverage, or denied or limited your eligibility, this document serves as part of your notice of the denial decision.

Your Right to Appeal

You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case.

Send a written appeal request to:
Blue Cross and Blue Shield of Illinois
Claim Review Section
PO Box 2401
Chicago, IL 60690

To file an appeal or if you have questions, please call 800-458-6024 (TTY/TDD: 711), send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members℠ (BAM℠) at bcbsil.com

Authorized Representative

You can name a person to act for you (including an attorney) on your appeal or external review – known as an "authorized representative." To use an authorized representative, you must first complete the necessary form. Call us at the number above to request the form, or to get more information if the person this document was sent to cannot act on his or her own. In urgent care situations, a doctor may act as your authorized representative without completing the form.

Standard Appeal

You, or an authorized representative (see above process for choosing someone to act for you), may appeal in writing or by phone. To send an appeal in writing use the contact information above and include any added information you want to give us as well as:

- A copy of the decision letter or Explanation of Benefits (EOB)
- The reference number or claim number (often found on the decision letter or EOB)

You can get copies free of charge of your relevant claim documents, including the rules, codes and guidelines we used in making a decision. To request the copies, use the contact information above. Unless your plan says otherwise, you have 180 calendar days from the date you received our initial decision to file your appeal.

What happens next?	We will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

Expedited (Urgent) Appeal

You, your authorized representative, or your doctor, can ask for an expedited appeal if you or your doctor believe that your life or health could be threatened by waiting for a standard appeal. To do so, you, your doctor, or your authorized representative, should call us at 800-458-6024 (TTY/TDD: 711) or fax your request to 918-551-2011. You have 180 calendar days to file your expedited appeal request. You may also ask for an Expedited External (Outside) Review, as described below, at the same time by calling 800-458-6024.

What happens next?	If you qualify for this type of appeal, we will give you a decision by phone within 72 hours after we receive your appeal request.

BlueCross BlueShield of Illinois

Your Right to a Standard External (Outside) Review	
You may ask for an external review with an Independent Review Organization (IRO) if your appeal was denied based on any of the reasons below. You may also ask for external review if we failed to give you a timely decision as stated in the Standard Appeal section above, and your claim was denied for one of these reasons: • A decision about the medical need for or the experimental status of a recommended treatment • A condition was considered pre-existing • Your health care coverage was rescinded (see your Benefit Booklet for details) If your case qualifies for external review, an IRO will review your case (including any data you'd like to add), at no cost to you, and make a final decision. To ask for an external review, you'll need to complete the necessary form and submit it to BCBSIL. You may get a form by calling the number on your ID card. Unless your plan says otherwise, you have 4 months from the date you received the decision notice to file your external review request.	
What happens next?	If you qualify for an External Review, an IRO will review your case and mail you its decision within 45 calendar days. That decision is final and binding on BCBSIL and you.

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If you used an in-network provider, your provider may be able to file an appeal request for benefits you've been denied. You and your provider may file appeals separately and at the same time. Deadlines for filing appeals or external review requests are not delayed by appeals made by your provider UNLESS you have chosen your provider to act for you as your authorized representative. Choosing your provider to act for you must be done in writing. If your provider is acting on your behalf, then the provider must meet the deadlines you would have to meet to file such requests.

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BlueCross BlueShield of Illinois

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IDOI
320 W. Washington St.
Springfield, Illinois 62767-0001

Review Request: 877-850-4740
Fax: 217-577-8495

IDOI, Office of Consumer Health Insurance
122 S. Michigan Ave .,19th Floor
Chicago, Illinois 60603

Complaints: 877-527-9431
Email: DOI.InfoDesk@illinois.gov

IDOI Web: https://mc.insurance.illinois.gov

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

Exhibit 3

BlueCross BlueShield of Illinois

May 19, 2023

S[redacted] L[redacted]
[redacted]
Portland OR[redacted]

Subscriber:	R[redacted] L[redacted]
Group/Sub. No.:	P17192[redacted]
Claim No.:	2104555F0630H, 2159551897W0H
Appeal ID No.:	[redacted]0595
Appeal Type:	Member
Phone:	(800)828-3116
Fax:	(918)551-2011
Email:	Appeals@bcbsil.com

Subject: Your Appeal Results

Dear S[redacted] L[redacted]:

We received your appeal on March 17, 2023, for the denial of the below treatment or service(s) for the below mentioned member. The appeal has been reviewed by an Appeals Specialist who was not involved in the prior denial. Supporting documentation of this appeal decision is listed below.

Appeal Decision	After careful review of the information we have, the appeal request has been **denied**.

Service(s)	Review of claims denials		
Member	S[redacted] L[redacted]	Provider	Kara Connelly, M.D.
Service Date(s)	March 30, 2022, May 24, 2022	Facility	N/A
Initial Decision	Transsexual surgery and related psychiatric care not covered.	Initial Decision Code	530
Initial Decision Date	June 08, 2022	Claim Amount	$173,335.22

The member has submitted an appeal regarding the above mentioned claims. The services were rendered on March 30, 2022 and May 24, 2022. After review, the claims are denied correctly based on the member's benefits. The denial states transsexual surgery and related psychiatric care not covered. Per the policy, services related to Gender Reassignment are not covered. It is an exclusion on the policy, which can be located on the Benefit Booklet on page 100. Benefits are recommended to be verified prior to services being rendered. Per the case notes on file, this was not done. A benefit verification would have shown the exclusion for the services. The Pre-Approval on file for the procedures are not a guarantee of payment. This information is also listed on the letters provided. Under the approval does not guarantee payment portion of the letter, it explains that the patient must be eligible to receive benefits. Therefore, per the information listed, services related to gender reassignment will not be eligible.

BlueCross BlueShield of Illinois

May 19, 2023

S[redacted] L[redacted]
[redacted]
Portland OR[redacted]

Subscriber:	R[redacted] L[redacted]
Group/Sub. No.:	P17192[redacted]
Claim No.:	2104555F0630H, 2159551897W0H
Appeal ID No.:	[redacted]0595
Appeal Type:	Member
Phone:	(800)828-3116
Fax:	(918)551-2011
Email:	Appeals@bcbsil.com

Procedure(s) Reviewed:
11981 (Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)), 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular), J1950 (Injection, leuprolide acetate (for depot suspension), per 3. 75 milligrams (mg)), J9226 (Histrelin implant (Supprelin LA) 50 milligrams (mg))

Additional information can be found in the member's SENTINEL TECHNOLOGIES Summary Plan Description and/or benefit booklet:

According to the "Exclusions-What Is Not Covered" section:

"Expenses for the following are not covered under your benefit program:

— Gender reassignment Surgery (also referred to as transsexual Surgery, sex reassignment Surgery or intersex Surgery), including related services and supplies."

There is one internal appeal available to you. Your internal appeal rights have now been exhausted.

The member or the authorized representative acting on behalf of the member may request, free of charge, a copy of any benefit provision, guideline, protocol, or other similar criterion that we relied upon to make this determination. The member may also, upon request, obtain free copies of all documents relevant to the appeal including the specific treatment and diagnosis code(s) and any new or additional evidence (if applicable) not utilized during the prior reviews.

If we accept a form naming an authorized representative it is not an acceptance of assignment or waiver of any anti-assignment provisions of the member's benefits information. Please refer to the anti-assignment provisions, if any, in the Summary Plan Description and/or benefit booklet for more information.

To receive benefits, you must be eligible. The terms, rules and limits of your plan will be applied. Benefits will also be based on whether the Provider(s) used for treatment are eligible with the plan's network. For more details, please refer to the member's benefits information.

If you have questions or to request copies, please contact Customer Service at (800)828-3116.

Sincerely,

Lindsay B.

BlueCross BlueShield of Illinois

May 19, 2023

S[redacted] L[redacted]
[redacted]
Portland OR[redacted]

Subscriber:	R[redacted] L[redacted]
Group/Sub. No.:	P17192[redacted]
Claim No.:	2104555F0630H, 2159551897W0H
Appeal ID No.:	[redacted]0595
Appeal Type:	Member

Phone: (800)828-3116
Fax: (918)551-2011
Email: Appeals@bcbsil.com

Lindsay B.
Appeals Specialist II
Appeals Department

Attachment:
IL02.G.UGF.F

BlueCross BlueShield of Illinois

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BlueCross BlueShield of Illinois

Department of Insurance

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IDOI
320 W. Washington St.
Springfield, Illinois 62767-0001

Review Request: 877-850-4740
Fax: 217-577-8495

IDOI, Office of Consumer Health Insurance
122 S. Michigan Ave .,19th Floor
Chicago, Illinois 60603

Complaints: 877-527-9431
Email: DOI.InfoDesk@illinois.gov

IDOI Web: https://mc.insurance.illinois.gov

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Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
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Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.