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October 04, 2021

No.:	21-71312
D.C. No.:	4:19-cv-00035-RM-LAB
Short Title:	State of Arizona, et al v. USDC-AZT

Dear Petitioners/Counsel

A petition for writ of mandamus and/or prohibition has been received in the Clerk's Office of the United States Court of Appeals for the Ninth Circuit. The U.S. Court of Appeals docket number shown above has been assigned to this case. Always indicate this docket number when corresponding with this office about your case.

If the U.S. Court of Appeals docket fee has not yet been paid, please make immediate arrangements to do so. If you wish to apply for in forma pauperis status, you must file a motion for permission to proceed in forma pauperis with this court.

Pursuant to FRAP Rule 21(b), no answer to a petition for writ of mandamus and/or prohibition may be filed unless ordered by the Court. If such an order is issued, the answer shall be filed by the respondents within the time fixed by the Court.

Pursuant to Circuit Rule 21-2, an application for writ of mandamus and/or prohibition shall not bear the name of the district court judge concerned. Rather, the appropriate district court shall be named as respondent.

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

In re: STATE OF ARIZONA, ANDY TOBIN, and PAUL SHANNON

STATE OF ARIZONA, ANDY TOBIN, PAUL SHANNON, Petitioners,

v.

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA,

Respondent.

RUSSELL B. TOOMEY, ARIZONA BOARD OF REGENTS D/B/A UNIVERSITY OF ARIZONA, RON SHOOPMAN, LARRY PENLEY, RAM KRISHNA, BILL RIDENOUR, LYNDEL MANSON, KARRIN TAYLOR ROBSON, JAY HEILER, FRED DUVAL, Real Parties In Interest

PETITION FOR A WRIT OF MANDAMUS

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I. INTRODUCTION

This Petition for Writ of Mandamus challenges the United States District Court for the District of Arizona's ("District Court") Order granting Plaintiff's Second Motion to Compel and compelling the disclosure of documents withheld pursuant to the attorney-client privilege by Defendants the State of Arizona, and Andy Tobin and Paul Shannon, both in their official capacities ("State Defendants"). (**Exhibit 1**, Order.) The District Court found that there was an implicit waiver of the attorney-client privilege by asserting an advice of counsel defense that there was no discriminatory intent when maintaining an exclusion for "gender reassignment surgery" in the State of Arizona's self-funded health plan.

State Defendants did not affirmatively assert an advice of counsel defense, nor did they imply such a defense in discovery or through any other actions. Rather, State Defendants accurately responded to interrogatories that they received legal advice, in addition to input from numerous other sources, regarding the implications of rules that had been published regarding the Affordable Care Act's ("ACA") provisions regarding non-discrimination set forth in ACA § 1557. State Defendants never asserted an advice of counsel defense, never indicated what the legal advice was, never indicated State Defendants relied on any such legal advice, and never put the lawyer's performance at issue during the course of litigation. State Defendants affirmatively asserted that any legal advice they received was privileged.

The attorney-client privilege is one of the oldest and most important privileges, and applies with special force in the governmental context because the privilege encourages government officials to consult with legal counsel when formulating policy. The privilege should not be deemed waived based on inaccurate or incomplete characterizations of accurate responses to interrogatories or without oral argument or an *in camera* review. The injury caused by an order requiring State Defendants to divulge privileged communications on the basis used by the District Court is too injurious to State Defendants and to the important privilege supported by sound public policy reasons. Forcing State Defendants to await a potential adverse judgment and appealing such a judgment cannot undo the harm caused if the District Court's order is not vacated.

State Defendants request that the Court grant this Petition and issue a Writ of Mandamus to the District Court directing it to vacate its order granting Plaintiff's Second Motion to Compel Production of Documents.

II. ISSUE PRESENTED

1. Did the District Court commit a clear error in granting Plaintiff's Second Motion to Compel Production of Documents and compelling the production of documents protected by the attorney-client privilege?

III. STATEMENT OF FACTS

This case was brought by Dr. Russell B. Toomey ("Plaintiff") against the State

of Arizona, Andy Tobin—the current Director of the Arizona Department of Administration ("ADOA")—in his official capacity, Paul Shannon—the current Director of the Benefits Services Division of ADOA—in his official capacity, the Arizona Board of Regents ("ABOR"), and the individual members of ABOR in their official capacities. (**Exhibit 2**, Amended Complaint.)

Plaintiff is a transgender man, which means that he has a male gender identity, but the sex assigned to him at birth was female. (*Id.* at ¶ 38.) Plaintiff alleges that he suffers from gender dysphoria, which is the diagnostic term for the clinically significant distress experienced as a result of the incongruence of one's gender with their assigned sex and the physiological developments associated with that sex. (*See id.* at ¶¶ 27, 39.) Plaintiff's physicians recommended that he undergo a total hysterectomy for treatment of his gender dysphoria. (*Id.* at ¶ 39.)

Plaintiff is employed as an Associate Professor by the Arizona Board of Regents at the University of Arizona. (*Id.* at ¶ 4.) The Arizona Board of Regents provides health insurance to its employees through the plans administered by ADOA. (*See id.* at ¶ 1, 32.) Plaintiff was enrolled in ADOA's self-insured Exclusive Provider Organization ("EPO") Plan (the "Plan"). (*See id.* at ¶ 1, 4, 32.)

Plaintiff sought coverage for a total hysterectomy to treat his gender dysphoria through the Plan. (*See id.* at ¶ 39.) While the Plan provides coverage for some gender transition services, including mental health counseling and hormone therapy, the

Plan excludes coverage for "gender reassignment surgery" (the "Exclusion"). (*See id.* at ¶ 36.) As a result, the Plan denied Plaintiff's request for coverage for a total hysterectomy. (*Id.* at ¶ 43.)

Plaintiff's first claim for relief alleges that Defendants violated Title VII of the Civil Rights Act of 1964 by maintaining the Exclusion because the Exclusion "*facially* discriminates based on transgender status and gender nonconformity." (*Id.* at ¶¶ 56–64 (emphasis added).) Plaintiff's second claim for relief alleges that Defendants violated the Equal Protection Clause of the Fourteenth Amendment by maintaining the Exclusion because the Exclusion "*facially* discriminates based on transgender status and gender nonconformity." (*Id.* at ¶¶ 65–81 (emphasis added)

On June 5, 2020, Plaintiff served his First Set of Interrogatories on Defendants. (**Exhibit 3**, Motion to Compel at Exhibit 4.) Interrogatory No. 1 requested that Defendants "[i]dentify and describe all reasons why the [Plan] excludes coverage for 'gender reassignment surgery.'" (*Id.* at 7.) Interrogatory No. 4 requested that Defendants "[i]dentify all persons who participated in formulating, adopting, maintaining, reviewing, approving, or deciding to continue the exclusion of coverage for 'gender reassignment surgery' from the Plan." (*Id.*) Interrogatory No. 7 requested that Defendants "[i]dentify all research, studies, data, reports, publications, testimony, or other documents considered, reviewed, or relied on by Defendants relating to the [] Exclusion." (*Id.* at 8.)

On September 28, 2020, State Defendants served their responses to Plaintiff's Interrogatories. (**Ex. 3**, Motion to Compel at Exhibit 3.) State Defendants' responses to Interrogatory Nos. 1, 4, and 7 are as follows:

> Answer[to Interrogatory No. 1]: The State of Arizona's self-funded health plan excludes coverage for gender reassignment surgery because the State concluded, under the law, that it was not legally required to change its health plan to provide such coverage under either Title VII of the Civil Rights Act or under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. Specifically, prior to the Supreme Court's ruling in Bostock v. Clayton County, Title VII protections on the basis of sex had not been applied to individuals based on their sexual orientation or transgender status. Further, rules promulgated by the Department of Health and Human Services ("HHS") regarding nondiscrimination provisions under Section 1557 of the Affordable Care Act prohibited blanket exclusions of all treatments of gender dysphoria, but did not require plans subject to the law to cover all treatments for gender dysphoria or gender transition services. The legal advice that the State received regarding this issue is covered by the attorney-client privilege.
>
> The State or governmental interests advanced by the exclusion are cost containment and reducing health care costs. The State gathered information from private insurers and public entities who did provide coverage for gender reassignment surgery in an effort to determine how its own health care costs would be impacted. Although the cost estimates varied, they unquestionably showed that removing the exclusion for gender reassignment surgery would increase costs and that such increases could be significant.

(*Id.* at 3.)

> Answer[to Interrogatory No. 4]: Defendants object to this interrogatory because it seeks information covered by the

> attorney-client privilege. Subject to and without waiving this objection, Defendants state that Michael T. Liburdi, the former General Counsel for the Office of the Arizona Governor, John M. Fry of the Arizona Attorney General's Office, Nicole A. Ong, the former General Counsel of the ADOA, Christina Corieri, Senior Policy Advisor Office of the Arizona Governor, Marie Isaacson, the former Director of the Benefits Services Division of the ADOA, and Paul Shannon, the Director of the Benefits Services Division of the ADOA participated in these decisions.

(*Id.* at 5.)

> Answer[to Interrogatory No. 7]: Defendants considered a Memorandum from Marie Isaacson to Mike Liburdi, General Counsel at the Governor's Office dated August 3, 2016, regarding Affordable Care Act § 1557, and a Memorandum regarding Non-discrimination—Transgender Coverage and a Memorandum from outside legal counsel at Fennemore Craig to Marie Isaacson dated July 20, 2016, regarding Summary and Implications of § 1557 and Transgender Coverage Requirements. Both of these documents are covered by the attorney-client privilege. Defendants also gathered information and data from insurers and other entities regarding their experience providing transgender benefits, including reassignment surgery. Plaintiffs may ascertain the non-privileged information requested in this Interrogatory from the documents that Defendants have produced in this action.

(*Id.* at 7–8.)

In addition, State Defendants served supplemental responses to Interrogatory Nos. 1 and 7 on January 21, 2021. (**Ex. 3**, Motion to Compel at Exhibit 5.) State Defendants' Supplemental Response to Interrogatory No. 1 stated:

> At some point prior to 2005, the State [] moved its healthcare coverage for employees to a self-funded health

> plan. At that time, the State maintained the same plan documents, including the same exclusions, as was utilized by the prior insurance providers. The plan documents included an exclusion for "transsexual surgery including medical or psychological counseling and hormone therapy in preparation for, or subsequent to, any such surgery."

(*Id.* at 3–4.) State Defendants' Supplemental Response to Interrogatory No. 7 stated:

> When the State [] transferred its healthcare coverage to a self-funded health plan, it adopted the coverages and exclusions utilized by its prior insurance providers, which included the prior iteration of the exclusion for gender reassignment surgery. No known additional documents were reviewed in relation to the transgender care exclusion until the issuance of ACA Rule 1557.

(*Id.* at 8.)

On December 8, 2020, Plaintiff served his First Set of Requests for Production. (**Ex. 3**, Motion to Compel at Exhibit 2.) Plaintiff's Request for Production No. 1 seeks:

> all documents related to the Plan's current or prior [] Exclusion, including, but not limited to . . . all documents . . . regarding whether any form of transition-related care or the [] Exclusion should be adopted, modified, retained, or eliminated, and the rationale provided or discussed [and] all documents and communications with internal and external persons pertaining to Defendants' initial decision to exclude transition-related care, as well as any subsequent decisions to adopt, amend, retain, or eliminate any form of transition-related care or the [] Exclusion."

(*Id.* at 17–18.) On January 21, 2021, State Defendants responded as follows:

> The State Defendants object to Request For Production No. 1 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose

> unreasonable costs on the State Defendants. The State Defendants further object that the scope of the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:
>
> The State Defendants will produce non-privileged documents responsive to Request For Production No. 1 in the possession, custody, and control of the Arizona Department of Administration. The State Defendants are not in possession, custody, or control of any Health Plan documents prior to 2005.

(**Exhibit 4**, Responses to Requests for Production at 4–5.) In connection with their responses to the Requests for Production, State Defendants produced several thousand documents. State Defendants withheld or redacted 88 documents on the basis of the attorney-client privilege.[1] (**Ex. 3**, Motion to Compel at Exhibit 9.)

[1] State Defendants also initially withheld or redacted approximately 65 documents on the basis of the deliberative process privilege or work product doctrine and redacted a further approximately 50 documents to limit the disclosure of confidential, irrelevant information, including information protected by the Health Insurance Portability and Accountability Act of 1996. These documents are not at issue in the instant Petition. Pursuant to a April 20, 2021 order, the State Defendants produced documents originally withheld solely on the basis of the deliberative process privilege.

IV. PROCEDURAL HISTORY

On May 20, 2021, Plaintiff filed his Second Motion to Compel Production of Documents (the "Motion"), seeking a court order compelling State Defendants to produce documents withheld on the basis of the attorney-client privilege. (**Ex. 3**.) Plaintiff contends that State Defendants waived the attorney-client privilege with respect to those documents by "asserting and relying on legal advice as a defense to the charge that discriminatory intent [motivated] [Defendants'] decision to maintain the Exclusion."[2] (*Id.*, at 2.) Plaintiff asserts that State Defendants placed the legal advice they received regarding the legality of the Exclusion at issue by asserting it in their Responses to his First, Fourth, and Seventh Interrogatories. (*Id.*, at 8–11.) Plaintiff further asserts that former Director of ADOA Benefits Service Division and ADOA Plan Administration Manager testified during their depositions that the decision to exclude gender reassignment surgery from coverage under the Plan was based on what the Plan was legally required to cover. (*Id.*)

State Defendants opposed Plaintiff's Motion. (**Exhibit 5**, Opposition to Motion to Compel.) State Defendants made clear that they never asserted an "advice-of-counsel" defense but were only responding fairly to the substance of Plaintiff's Interrogatories. (*Id.*, at 4–9.) State Defendants argued that indicating that counsel

[2] Plaintiff also asserted that State Defendants waived the attorney-client privilege by disclosing the substance of it during depositions. (**Ex. 3**, at 11–13.) However, the District Court's order did not reach this argument by Plaintiff. (**Ex. 1**, Order.)

was consulted in the course of a decision does not waive the privilege or implicitly raise an "advice-of-counsel" defense. (*Id.*) State Defendants also requested that the Court conduct an *in camera* review of the documents at issue. (*Id.*, at 17.)

On June 28, 2021, without entertaining any argument on the Motion or conducting an *in camera* review of the subject documents, the Magistrate Judge adopted Plaintiff's arguments and granted the Motion. (**Exhibit 6**, Order (the "Magistrate Order").) The Magistrate Judge ruled that State Defendants *implicitly* waived the attorney-client privilege with respect to the withheld documents by asserting an advice of counsel defense as "evidence that they harbored no discriminatory intent" in maintaining the Exclusion. (*Id.* at 4.) The Magistrate Judge relied on State Defendants' Interrogatory Responses and deposition testimony in reaching this conclusion. (*Id.* at 4–6.) The Magistrate Order concluded that Plaintiff cannot realistically dispute State Defendants' claimed reason for maintaining the Exclusion without access to the attorney-client privileged documents and that "fairness" thus mandates that Plaintiff be able to review the legal advice. (*Id.* at 5–6.)

State Defendants appealed the Magistrate Order to the District Court Judge. (**Exhibit 7**, State Defendants' Objections to Order .) Again, State Defendants clarified that they have not asserted an "advice-of-counsel" defense. (*Id.* at 1–6.) State Defendants emphasized that the attorney-client privilege is too important to be

waived based on inaccurate or incomplete characterizations. (*Id.*) State Defendants urged the District Court to reverse the Magistrate Order and deny Plaintiff's Motion. (*Id.* at 10.) State Defendants also requested oral argument. (*Id*.)

On September 21, 2021, the District Court denied the State Defendant's objection. (**Ex. 1**, at 7 (the "Order").) Again, the District Court did not entertain any argument or complete an *in camera* review. (*See id.*, at 1, n.1.) The Order summarily disposes of State Defendants' objections in one, single paragraph:

> The record supports affirming Magistrate Judge Bowman's Order compelling production of the withheld documents. The Court's review of the record reveals that, despite the State Defendants' protestations to the contrary, the State Defendants' Interrogatory Responses indicate that they relied on the advice of legal counsel in deciding to maintain the exclusion of coverage for gender reassignment surgery. (See Doc. 195-3 at 28-37.) This constitutes an affirmative act placing the privileged materials at issue. Furthermore, as Judge Bowman concluded, Plaintiff is unable to adequately respond to this defense without viewing the withheld documents. Without disclosure of the withheld documents, Plaintiff cannot fully respond to Defendants' argument that their reason for maintaining the exclusion was lawful and non-discriminatory because it was based on legal advice. As such, fairness mandates that the documents be disclosed. While the Court acknowledges that the public policy underlying the attorney-client privilege serves to protect the State's ability to engage in privileged communications with its lawyers, that interest does not overcome Plaintiff's right to fully litigate the merits of this action.

(*Id.*, at 8.)

V. A WRIT OF MANDAMUS SHOULD ISSUE

A. Standard For Issuance Of A Writ of Mandamus

This Court has jurisdiction over this case because it is pending in the United States District Court for the District of Arizona. *See* 28 U.S.C. § 1294(1). This Court has jurisdiction to issue writs of mandamus to district courts under 28 U.S.C. § 1651; *see In re U.S.*, 791 F.3d 945, 951 (9th Cir. 2015). Historically, a writ of mandamus is an order that compels a court or officer to act. *Id*. at 953. A writ of mandamus is used to "confine an inferior court to a lawful exercise of its prescribed jurisdiction or to compel it to exercise its authority when it is its duty to do so." *Credit Suisse v. U.S. Dist. Court for Cent. Dist. of California*, 130 F.3d 1342, 1345 (9th Cir. 1997). State Defendants request that this Court compel the District Court to vacate its grant of Plaintiff's Second Motion To Compel Production of Documents.

This Court determines *de novo* whether a writ should issue.[3] *In re Orange, S.A.*, 818 F.3d 956, 961 (9th Cir. 2016). A writ of mandamus is available when: (1) the party seeking issuance of the writ has no other adequate means to obtain the desired relief; (2) the petitioner's right to issuance of the writ is "clear and

[3] The Court reviews *de novo* a district court's rulings on the scope of the attorney-client privilege. *See Clarke v. American Commerce Nat'l Bank*, 974 F.2d 127, 130 (9th Cir. 1992). The Ninth Circuit reviews a district court's order concerning discovery for an abuse of discretion. *Goodman v. Staples The Office Superstore, LLC*, 644 F.3d 817, 822 (9th Cir. 2011); *see also Epstein v. MCA, Inc.*, 54 F.3d 1422, 1423 (9th Cir. 1995) ("An order compelling a party to comply with discovery requests is reviewed for abuse of discretion.").

indisputable;" and (3) the issuing court is satisfied that the writ is appropriate under the circumstances." *In re U.S.*, 791 F.3d at 954–55. "Mandamus is appropriate to review discovery orders when particularly important interests are at stake." *Hernandez v. Tanninen*, 604 F.3d 1095, 1099 (9th Cir. 2010) (*citing Perry v. Schwarzenegger*, 591 F.3d 1147, 1156–57 (9th Cir. 2010)); *see also Mohawk Indus., Inc. v. Carpenter*, 558 U.S. 100, 111, 130 S. Ct. 599, 607, 175 L. Ed. 2d 458 (2009) (identifying mandamus review as a possible remedy for a particularly injurious attorney-client privilege ruling).

This Court utilizes the *Bauman* factors to determine whether to issue a writ:

> (1) The party seeking the writ has no other adequate means, such as a direct appeal, to attain the relief he or she desires. (2) The petitioner will be damaged or prejudiced in a way not correctable on appeal. (This guideline is closely related to the first.) (3) The district court's order is clearly erroneous as a matter of law. (4) The district court's order is an oft-repeated error, or manifests a persistent disregard of the federal rules. (5) The district court's order raises new and important problems, or issues of law of first impression.

In re U.S., 791 F.3d at 955 (citing *Bauman v. U.S. District Court*, 557 F.2d 650, 654–55 (9th Cir. 1977)); *see also In re Orange*, 818 F.3d at 961.

These five factors "often raise questions of degree and proper disposition requires a balancing of conflicting indicators." *Id.* (internal citations omitted). No single *Bauman* factor is determinative and all five factors need not be established at the same time for a writ to properly issue. *Id.*; *see also In re U.S.*, 791 F.3d at 955; *Credit Suisse*, 130 F.3d at 1345 (granting a petition for writ of mandamus where

only three guidelines were present and stating "rarely will a case arise where all these guidelines point in the same direction or where each guideline is even relevant or applicable"). This Court generally requires that the third factor—clear error as a matter of law—be satisfied before issuing a writ. *See in re U.S.*, 791 F.3d at 955.

Here, four of the *Bauman* factors weigh in favor of issuing a writ of mandamus: (1) State Defendants have no other means of relief; (2) the prejudice to State Defendants from production cannot be remedied on appeal from a final judgment; (3) the District Court's order is clearly erroneous; and (4) the District Court's order disregards the federally-recognized attorney-client privilege.

B. State Defendants Have No Other Means of Relief.

This factor is easily satisfied here. First, State Defendants have exhausted all available means for relief. State Defendants opposed Plaintiff's Motion. (**Ex. 5**.) The Magistrate Judge rejected State Defendants' arguments and granted the Motion. (**Ex. 6**.) State Defendants then objected to the Magistrate Order. (**Ex. 7**.) Their objection was denied by the District Court and the District Court affirmed the Magistrate Judge's order compelling production. (**Ex. 1**.) Both the Magistrate Judge and the District Court failed to entertain any argument on the Motion or conduct an *in camera* review, which would have presented State Defendants a further opportunity to obtain the necessary relief without bringing the issue before this Court.

Second, State Defendants cannot appeal the Order to this Court through any

mechanism other than a Petition for Writ of Mandamus. The Order is not appealable. It is not a final judgment, is not appealable as a matter of right under 28 U.S.C. § 1292(a), and does not present a question which can be certified for appeal pursuant to 28 U.S.C. § 1292(b). *See Hernandez*, 604 F.3d at 1101 (an order compelling production of privileged documents is "interlocutory and non-appealable"). The Order is also not appealable under the collateral order doctrine. *See id.; Mohawk Indus.*, 558 U.S. at 114. The Supreme Court explained in *Mohawk Indus.* that petitioning the Court of Appeals for a Writ of Mandamus when there is a manifest injustice is an appropriate approach.[4] 558 U.S. at 111.

The first *Bauman* factor supports granting the Petition.

C. State Defendants Will Be Prejudiced By Production Of The Privileged Documents And The Prejudice Cannot Be Corrected After Production.

There can be no dispute that State Defendants will be prejudiced by the production of documents protected by the attorney-client privilege. The privilege applies to a confidential communication between attorney and client if that communication was made for the purpose of obtaining or providing legal advice to the client. *See* 1 Restatement (Third) Of The Law Governing Lawyers §§ 68–72 (2000). The attorney-client privilege is "the oldest of the privileges for confidential

[4] Alternatively, a party could disregard an order, incur court-imposed sanctions, and then appeal those sanctions. *Mohawk Indus.*, 558 U.S. at 111. State Defendants have no intention of pursuing that option.

communications known to the common law." *Upjohn Co. v. United States*, 449 U.S. 383, 389, 101 S. Ct. 677, 682, 66 L. Ed. 2d 584 (1981); *see also Mohawk Indus.*, 558 U.S. at 108 ("[w]e readily acknowledge the importance of the attorney-client privilege"). The privilege is necessary to "encourage full and frank communications between attorneys and their clients" because proper legal assistance can only be given when it is free from "consequences or the apprehension of disclosure." *Upjohn*, 449 U.S. at 389. The privilege applies equally to individuals, corporations, and other entities, including government entities. *Id*. at 389–90; *Commodity Futures Trading*, 471 U.S. 343, 348 (1985) (inanimate entities can assert the attorney-client privilege just as an individual can); A.R.S. § 12-2234(B).

This prejudice cannot be remedied upon appeal from a final judgment. The attorney-client privilege provides clients with a right not to disclose privileged information in the course of litigation. *See Mohawk Indus.*, 558 U.S. at 109 ("an order to disclose privileged information intrudes on the confidentiality of attorney-client communications"). As this Court has recognized, "[a] post-judgment appeal would not provide an effective remedy" for compelled production of privileged materials because "no such review could prevent the damage that [Petitioners] allege they will suffer or afford effective relief." *Perry v. Schwarzenegger*, 591 F.3d at 1157–58; *see also Star Editorial, Inc. v. U.S. Dist. Court for Cent. Dist. of California*, 7 F.3d 856, 859 (9th Cir. 1993) ("[I]f the district court erred in

compelling disclosure [of documents protected by reporter's privilege], any damage the [newspaper] suffered would not be correctable on appeal."); *Admiral Ins. Co. v. U.S. Dist. Court for Dist. of Arizona*, 881 F.2d 1486, 1491 (9th Cir. 1989) ("if Admiral is forced to produce a privileged statement, it will be injured in a way not correctable on appeal"). This makes sense because the damage caused by production of privileged materials comes from the disclosure itself, entirely aside from later use of the materials in motion practice or at trial. The production cannot effectively be unwound at a later date.

Although in *Mohawk Indus.*, the Supreme Court found that post-judgment remedies "generally suffice" to protect the rights of litigants who are compelled to produce privileged materials, the Court observed that post-judgment appeals may not be sufficient for "correcting serious errors" such as a "particularly injurious or novel privilege ruling." 558 U.S. at 110–11. For example, in *Hernandez*, this Court found that an order compelling production of attorney-client privileged documents was "particularly injurious" because the "breadth of the waiver finding [was] untethered to the subject-matter disclosed" and it "could result in matters far beyond the scope of the waiver being disclosed, including case strategy, the strengths and weaknesses of [Petitioner's] claims, and all communications between [the attorney] and [Petitioner]." 604 F.3d at 1101; *see also Perry v. Schwarzenegger*, 591 F.3d at 1158 (post-judgment appeal would not provide an effective remedy for order

compelling production of documents protected by the First Amendment because "[o]ne injury to Proponents' First Amendment rights is the disclosure itself").

Compelling a government entity to produce documents protected by the attorney-client privilege is such a "particularly injurious" or "novel" issue. *See United States v. Jicarilla Apache Nation*, 564 U.S. 162, 166, 131 S. Ct. 2313, 2318, 180 L. Ed. 2d 187 (2011) (granting writ of mandamus to review order to produce attorney-client privilege documents held by federal government); *In re City of Houston*, 772 Fed. App'x 143, 144 (5th Cir. 2019) (granting writ of mandamus to review order to produce attorney-client privilege documents held by City). This is because allowing the government to engage in privileged communications with legal counsel is uniquely important. As the Second Circuit explained,

> In the context of legal advice to government officials, the privilege furthers a culture in which consultation with government lawyers is accepted as a ***normal, desirable, and even indispensable*** part of conducting public business. Abrogating the privilege undermines that culture and thereby ***impairs the public interest.***

Am. C.L. Union v. Nat'l Sec. Agency, 925 F.3d 576, 589 (2d Cir. 2019) (internal quotations omitted) (emphasis added). The privilege applies with "special force" in the government context because the privilege encourages government officials formulating policies in the public interest to consult with counsel. *Modesto Irrigation Dist. v. Gutierrez*, 1:06-CV00453 OWWDLB, 2007 WL 763370, at *13 (E. D. Cal. Mar. 9, 2007). The second *Bauman* factor supports granting the Petition.

D. The District Court's Order Compelling Production Is Clearly Erroneous.

1. State Defendants Did Not Assert An "Advice-of-Counsel" Defense.

The Order finds that "State Defendants' Interrogatory Responses indicate that they relied on the advice of legal counsel in deciding to maintain the [E]xclusion."[5] (**Ex. 1** at 8.) This finding is clearly erroneous.

The privilege is ***only*** waived when "a party, in the course of litigation, (1) makes an affirmative act injecting privileged materials into a proceeding, (2) thereby putting the materials at issue, (3) where application of the privilege would deny the opposing party access to information needed to effectively litigate its rights in the adversarial system." *United States v. Amlani*, 169 F.3d 1189, 1195 (9th Cir. 1999); *see also Melendres v. Arpaio*, No. CV-07-2513-PHX-GMS, 2015 WL 12911719, at *2 (D. Ariz. May 14, 2015). "[D]isclosing that legal counsel was consulted, the subject about which advice [was] received, or that action was taken based on that advice, ***does not necessarily waive the privilege protection***." *Melendres*, 2015 WL 12911719, at *3 (emphasis added).

[5] Plaintiff argued that State Defendants also waived the privilege in deposition testimony (**Ex. 3**, Motion to Compel at 8–11), and the Magistrate Order relied upon that testimony in finding a waiver (**Ex. 6**, Magistrate Order at 5). As outlined in State Defendants' opposition to the Motion and objection to the Magistrate Order, State Defendants' witnesses' testimony did not assert an advice of counsel defense. (**Ex. 5**, Opposition to Motion to Compel at 11–12; **Ex. 7**, Objections to Order at 6–7.) State Defendants do not address this rationale in detail here because the District Court's Order does not adopt it in affirming the Magistrate's Order.

Plaintiff claims State Defendants affirmatively asserted an advice of counsel defense in responses to Interrogatory Nos. 1, 4, and 7. (**Ex. 3**, Motion to Compel at 8–11.) In their Interrogatory Responses, however, State Defendants never disclosed: (1) what the legal advice was; (2) whether there was any recommendation from legal counsel; (3) whether State Defendants relied upon any advice from legal counsel; (4) whether actions were based on or justified by legal advice; or (5) what attorneys gave legal advice—whether outside legal counsel, in-house counsel at ADOA or the Governor's Office, or the Attorney General's Office. (**Ex. 3**, Motion to Compel at Exhibit 5.) State Defendants simply and truthfully acknowledged that legal counsel was among those consulted regarding the Exclusion. Under governing case law, that does not waive the privilege.

a. Interrogatory No. 1

Plaintiff's Interrogatory No. 1 requests that State Defendants "identify and describe all reasons" why the State maintained the Exclusion. (*Id.,* at 2–3.)

To comply with Interrogatory No. 1, State Defendants' response identifies and describes several reasons for the Exclusion, including cost containment, reducing healthcare costs, and industry standards. (*Id.*) One of the many reasons State Defendants kept the Exclusion is that they concluded it was not required to remove the Exclusion or to cover all gender reassignment treatments or services. (*Id.*) However, State Defendants' response does not state where they obtained their

understanding of the law and certainly does not state that they relied on the advice of counsel in reaching this understanding, and the Interrogatory did not require State Defendants to do so. (*Id.*) As the Magistrate Order acknowledges, State Defendants' understanding of the law could be based on several non-privileged sources (such as newspaper articles). (**Ex. 6**, Magistrate Order at 5–6.) The documents produced in this matter show that ADOA, in fact, did review and interpret § 1557 itself, and also received interpretations of § 1557, and the legal impact of the Rule, from each of its insurance vendors, medical consultants, news sources, and public presentations. (**Ex. 7**, Objections to Order.) For example, ADOA requested interpretations of § 1557 from each of its insurance carriers and Mercer, an insurance consulting firm, and consolidated that information into a research memo. (*Id.* at 4.) ADOA also reviewed publications from several entities, including ADP (a well-known human resources and payroll service provider) and the Department of Health and Human Services. (*Id.* at 4.) In fact, the only reference to legal advice in the response to Interrogatory No. 1 was an *assertion* of the privilege, not a waiver. (**Ex. 3**, Motion to Compel at Exhibit 5 at 2 ("The legal advice that the State [Defendants] received regarding [§ 1557] is covered by the attorney-client privilege."). Furthermore, State Defendants' response to Interrogatory No. 1 nowhere states who provided legal advice, what the legal advice was, or even that the State relied on the legal advice to make its determination. (*See id.* at 1–3.) Nothing therein asserted or implied a waiver of the

privilege.

State Defendants' extensive research into § 1557 makes sense in light of the novel legal landscape at the time. Prior to 2015, no health plans were required to cover transgender benefits under any law. On May 18, 2016, the Office of Civil Rights of the United States Department of Health and Human Services ("HHS") issued a final rule implementing non-discrimination provisions under § 1557 (the "2016 Rules"). *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376 (May 18, 2016) (codified at 45 C.F.R. 92). Notably, the 2016 Rules prohibited entities subject to the Rules from including categorical exclusions or limitations for health services related to "gender transition." 45 CFR § 92.207(b)(4) (2016). However, the 2016 Rules did not affirmatively require coverage of any particular procedure or treatment for gender transition-related care. *Id*. at § 92.207(d). Further complicating matters, the 2016 Rules were challenged in court to determine if they were valid or whether they exceeded what is meant by "on the basis of sex" under the law.

The language of § 1557 is concise. Regarding discrimination on different bases, § 1557 incorporates different federal discrimination laws. *See* 42 U.S.C. § 18116(A). For discrimination on the basis of sex, § 1557 incorporates Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.). *Id*.[6] Challenges to the

[6] Section 1557 does not incorporate Title VII's definition of "on the basis of sex."

validity of the 2016 Rules occurring when State Defendants were considering changes to the Plan focused on whether the 2016 Rules improperly exceeded the scope of what is meant by discrimination on the basis of sex in Title IX.[7]

On December 31, 2016, the United States District Court for the Northern District of Texas granted a motion for preliminary injunction enjoining HHS from enforcing § 1557 prohibitions against discrimination on the basis of gender identity because the definition of sex under the 2016 Rules exceeded the scope of Title IX. *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 696 (N.D. Tex. 2016). This case and related motions were pending when the ADOA was evaluating how it would address § 1557. Nevertheless, the day after Texas District Court's ruling, the Plan ***expanded*** transgender benefits to include hormone and counseling treatment, effective January 1, 2017.[8] This is despite the fact that there has continued to be

[7] The purpose of Title IX, when passed into law in 1972, was to establish equal educational opportunities for women and men. *Lothes v. Butler Cnty. Juvenile Rehab. Ct.*, 243 Fed. App'x. 950, 955 (6th Cir. 2007). Discrimination on the basis of sex under Title IX originally meant male and female under traditional binary concepts of sex that is consistent with a person's birth or biological sex. *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1222 (10th Cir. 2007). For many years, including shortly prior to the ADOA's decision to modify the Exclusion, courts held that discrimination on the basis of gender identity was not covered by Title IX. *See e.g.*, *Johnston v. Univ. Pittsburgh*, 97 F.Supp. 3d 657 (W.D. Penn 2015).

[8] Other cases challenging the meaning of "on the basis of sex" under Title IX were also occurring in 2016 when State Defendants were considering changes to the Exclusion. On August 21, 2016, the Federal District Court for the District of Northern Texas issued a preliminary injunction enjoining the Department of Education from enforcing guidance it had issued regarding transgender student

uncertainty regarding the validity and enforcement of § 1557 to present. The proper interpretation of § 1557 has yet to be resolved.

In conclusion, State Defendants' response to Interrogatory No. 1 did not assert that they relied on the advice of counsel and, thus, did not waive the privilege.

b. Interrogatory No. 4[9]

Interrogatory No. 4 requests an identification of "persons who participated in formulating, adopting, maintaining, reviewing, approving or deciding to continue" the Exclusion. (**Ex. 3**, Motion to Compel at Exhibit 5 at 5.) State Defendants' response identifies six people, three of whom are attorneys. (*Id.*) This is not a waiver.

As an initial point, Interrogatory No. 4 is extremely compound. A person listed could have been involved in reviewing the Exclusion, but might not have been involved in any other way such as formulating, adopting, maintaining, approving, or deciding anything about the Exclusion. State Defendants' response to Interrogatory

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access to school facilities including restrooms. *Texas v. United States*, 201 F. Supp. 3d 810, 836 (N.D. Tex. 2016). The guidance, which included gender identity under Title IX protections against discrimination on the basis of sex, exceeded the scope and plain meaning of Title IX. *Id*. at 832-33. ("It cannot be disputed that the plain meaning of the term sex as used in § 106.33 when it was enacted . . . following passage of Title IX meant the biological and anatomical differences between male and female students as determined at their birth.").

[9] It is unclear if Interrogatory No. 4 is a basis for the District Court's waiver finding. The Magistrate Order does not reference State Defendants' Response to Interrogatory No. 4 (*see generally* **Ex. 6**), but the Order does not state which "Interrogatory Responses" it believes "indicate that [State Defendants] relied on the advice of legal counsel" (*see* **Ex. 1**, Order at 8). To be clear, no interrogatory responses state affirmatively or imply reliance on advice of counsel.

No. 4 provides no basis to find that any attorneys were involved in the decision to maintain the Exclusion. Plaintiff's argument on this point and the District Court's adoption of Plaintiff's argument clearly overreaches.

In addition, *assuming arguendo* that the attorneys identified in response to Interrogatory No. 4 were involved in the decision to maintain the Exclusion, that still does not constitute a waiver of the attorney-client privilege. It is well established that not every communication between an attorney and a client is privileged. A communication is privileged only when it is made for the purpose of obtaining legal advice. *United States v. Sanmina Corp.*, 968 F.3d 1107, 1116 (9th Cir. 2020); *United States v. Graf*, 610 F.3d 1148, 1156 (9th Cir. 2010). Nothing in State Defendants' response to Interrogatory No. 4 states or even suggests that the attorneys involved gave legal advice regarding the Exclusion. (**Ex. 3**, Motion to Compel at Exhibit 5 at 5.) Further, the facts communicated from a client to his or her counsel are not covered by the privilege. *Upjohn*, 449 U.S. at 395. Similarly, the fact that counsel was consulted is not privileged. *See, e.g.*, *Colton v. United States*, 306 F.2d 633, 636 (2d Cir. 1962); *State v. Alexander*, 108 Ariz. 556, 568 (1972) ("The privilege extends only to confidential [c]ommunications between the client and his attorney. Thus, the fact that the client has consulted an attorney, the dates and places of his visits, the identity of the client, and similar matters are outside the coverage of the privilege.") (citation omitted). As such, State Defendants'

identification of the fact that attorneys were present at a meeting and may have reviewed the Exclusion does not reveal any privileged information and does not waive the privilege. *See United States v. White*, 887 F.2d 267, 271 (D.C. Cir. 1989) ("An averment that lawyers have looked into a matter does not imply an intent to reveal the substance of the lawyers' advice. Where a defendant neither reveals substantive information, nor prejudices the government's case, nor misleads a court by relying on an incomplete disclosure, fairness and consistency do not require the inference of waiver."). State Defendants' response to Interrogatory No. 4 did not assert or imply that they relied on the advice of counsel and, thus, did not waive the attorney-client privilege.

c. Interrogatory No. 7

Plaintiff's Interrogatory No. 7 requests an identification of all documents "considered, reviewed, or relied on" by State Defendants relating to the Exclusion. (**Ex. 3**, Motion to Compel at Exhibit 5 at 7.) State Defendants' response identified several documents and sources, including documents from their insurance carriers and other industry organizations. (*Id.* at 7–8.) At issue here is State Defendants' identification of two communications with legal counsel: one memorandum from outside legal counsel to ADOA and another memorandum from ADOA to legal counsel at the Governor's Office. (*Id.*)

Again, Plaintiff's Interrogatory is so compound as to make it ambiguous. It

cannot be said from the response that the legal memoranda were "relied upon" rather than simply "considered[or] reviewed." In fact, the response actually states that State Defendants "considered" the memoranda. (*Id.* at 7–8.) State Defendants did not disclose any legal advice contained therein, did not indicate there was a recommendation from legal counsel, and did not state that State Defendants relied on any advice of legal counsel. (*Id.*) Moreover, State Defendants' response to Interrogatory No. 7 explicitly identifies several non-privileged documents that were gathered from "insurers and other entities" regarding coverage for transgender healthcare benefits. (*Id.*) Nothing in State Defendants' response to Interrogatory No. 7 suggests that State Defendants "primarily" or "in large part" or in any other way *relied* on the advice of counsel for its understanding of the law, as suggested in the Magistrate Order and adopted by the District Court. (*Id.*) State Defendants' response to Interrogatory No. 7 provides no basis to find that they relied upon the legal memoranda in any way.

This is especially so because the Interrogatory requests all documents "related to" the Exclusion, not just those that were considered, reviewed, or relied upon in State Defendants' decision to maintain the Exclusion. (*Id.* at 7.) State Defendants' response to Interrogatory No. 7 provides no evidence or reasonable inference that State Defendants relied upon any memorandum from legal counsel in making the decision to maintain the Exclusion.

2. Plaintiff's Causes of Action Allege Facially Discriminatory Plan Terms—Not Discriminatory Intent.

Plaintiff argued that the withheld, privileged communications are relevant to prove State Defendants' alleged discriminatory intent. (**Exhibit 8**, Plaintiff's Reply in support of Motion to Compel at 2.) The Order, in turn, grants the Motion because "[w]ithout disclosure of the withheld documents, Plaintiff cannot fully respond to [the State] Defendants' argument that their reason for maintaining the [E]xclusion was lawful and non-discriminatory." (**Ex. 1**, Order at 7.)

However, the Order ignores the fact that Plaintiff did not plead any discriminatory intent on behalf of State Defendants. (*See generally* **Ex. 2**.) Both of Plaintiff's claims for relief allege that the Exclusion "***facially discriminates*** based on transgender status and gender nonconformity." (*Id.* at ¶¶ 56–81.) Indeed, Plaintiff's Amended Complaint never once uses the word "intent" or "intended." (*See id.* .) Plainly, whether or not State Defendants acted with any discriminatory intent is not relevant to Plaintiff's claims.[10] Plaintiff's desire to demonstrate that State Defendants are bad actors or have bad intent does not make the privileged communications relevant to his claims of facial invalidity.

E. <u>The District Court's Order Disregards The Federally Established Attorney-Client Privilege.</u>

The Order addresses the importance of the attorney-client privilege and the

[10] To be clear, State Defendants did not act with any discriminatory intent or animus.

implications of compelling production in a single, conclusory sentence:

> While the Court acknowledges that the public policy underlying the attorney-client privilege serves to protect the State's ability to engage in privileged communications with its lawyers, that interest does not overcome Plaintiff's right to fully litigate the merits of this action.

(**Ex. 1**, Order at 7.) The action, as alleged by Plaintiff, is that the Plan exclusion for gender transition surgery is facially discriminatory.

The District Court's ruling encompasses too much. Obtaining privileged communications will ***always*** assist a party in overcoming an opposing party's claim or defense but that does not make the communications discoverable. *See* Fed. R. Civ. P. 26(b)(1) (parties may obtain discovery of any relevant, ***nonprivileged*** matter) (emphasis added). The privilege exists to protect advice of counsel to his or her client. The fact that a party admits that counsel was consulted cannot in and of itself be a waiver of the privilege or the privilege is meaningless.

Furthermore, the Court's conclusion and Plaintiff's arguments put State Defendants in a no-win situation. On the one hand, government entities are tasked with developing policies for the benefit of the public and in its interest. In this context, government officials are encouraged to consult with counsel.[11] *See Modesto*

[11] Indeed, there are several privileges that apply to governments engaged in policy-making to encourage full and frank discussions. *See* 5 U.S.C. § 552(b)(5) (1996) (deliberative-process privilege); *Karnoski v. Trump*, 926 F.3d 1180, 1204 (9th Cir. 2019) (executive communications privilege); A.R.S. § 38-431.03(D) (privilege for discussions occurring in executive sessions of Arizona governmental entities).

Irrigation Dist., 2007 WL 763370 at *13. As the Second Circuit recognized,

> In the context of legal advice to government officials, the privilege furthers a culture in which consultation with government lawyers is accepted as a ***normal, desirable, and even indispensable*** part of conducting public business. Abrogating the privilege undermines that culture and thereby ***impairs the public interest.***

Am. C.L. Union v. Nat'l Sec. Agency, 925 F.3d at 589 (internal quotations omitted) (emphasis added). Allowing the government to engage in privileged communications with legal counsel is uniquely important.

On the other hand, however, the Order finds that State Defendants' mere acknowledgement that they wanted to follow the law, obtained legal advice, and made a decision *waived* the attorney-client privilege. The effect of holding that such an acknowledgment is itself a waiver is that government officials can never assume their attorney-client communications are privileged and will be discouraged from seeking legal counsel, which undermines both good public policy and the purpose of the attorney-client privilege.

VI. CONCLUSION

For the foregoing reasons, State Defendants respectfully request that the Court grant this Petition and issue a Writ of Mandamus to the District Court directing it to vacate the order granting Plaintiff's Second Motion to Compel Production of Documents.

DATED this 4th day of October, 2021.

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By: s/ Timothy J. Berg
Timothy J. Berg
Amy Abdo
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Attorneys for Petitioners
STATE OF ARIZONA, ANDY
TOBIN, PAUL SHANNON

STATEMENT OF RELATED CASES

Pursuant to Circuit Rule 28-2.6, the State of Arizona, Andy Tobin, and Paul Shannon state that they are unaware of any related, pending cases before this Court.

DATED this 4th day of October, 2021.

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing Petition for Writ of Mandamus with the Clerk of the Court for the United States Court of Appels for the Ninth Circuit by using the appellate CM/ECF system on October 4, 2021. The undersigned further certifies that on October 4, 2021, the Petition for Writ of Mandamus was served by mail on all participants listed below:

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EXHIBIT 1

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Russell B Toomey,

Plaintiff,

v.

State of Arizona, et al.,

Defendants.

No. CV-19-00035-TUC-RM (LAB)

ORDER

Pending before the Court is Defendants State of Arizona, Andy Tobin, and Paul Shannons' ("State Defendants") Appeal (Doc. 223) of the Magistrate Judge's Order (Doc. 213) Granting Plaintiff's Second Motion to Compel Production of Documents (Doc. 195). Plaintiff responded to the Appeal. (Doc. 232.) For the following reasons, the Appeal will be denied and Magistrate Judge Leslie A. Bowman's Order granting the Motion to Compel will be affirmed.[1]

I. Background

Plaintiff Dr. Russell B. Toomey is a transgender male who is employed as an Associate Professor at the University of Arizona. (Doc. 86 at 3, 5.)[2] His health

[1] The Court finds that the Appeal is suitable for decision without oral argument and accordingly denies the State Defendants' request for oral argument.
[2] All record citations herein refer to the document and page numbers generated by the Court's electronic filing system.

insurance—a self-funded plan ("the Plan") controlled by the Arizona Department of Administration ("ADOA")—categorically excludes "gender reassignment surgery" from coverage. (*Id.* at 5, 8-9.) Plaintiff brings this class action lawsuit alleging that the exclusion of gender reassignment surgery is sex discrimination under Title VII of the Civil Rights Act and a violation of the Fourteenth Amendment Equal Protection Clause. (*Id.* at 13-17.) One of the disputed factual questions in this case is "[w]hether the decision to exclude gender reassignment surgery in [the Plan] was actually motivated by a legitimate governmental interest." (Doc. 128 at 11.)

Plaintiff served Defendants with his first set of Requests for Production on December 8, 2020. (Doc. 195 at 1; Doc. 195-3 at 8-27.) Requests for Production One, Three, and Nine sought documents and information concerning the Plan's exclusion of gender reassignment surgery and the decision-making behind the exclusion. (Doc. 195 at 4; Doc. 195-3 at 23-26.) The State Defendants withheld 85 documents as attorney-client privileged.

II. Plaintiff's Motion to Compel

Plaintiff seeks to compel disclosure of the 85 documents that the State Defendants have withheld based on their assertion of the attorney-client privilege. (Doc. 195 at 2.) Plaintiff contends that the State Defendants waived the attorney-client privilege with respect to those documents: (1) "by asserting and relying on legal advice as a defense to the charge that discriminatory intent [motivated] [Defendants'] decision to maintain the Exclusion," and (2) by voluntarily disclosing the substance of the legal advice. (*Id.* at 3-4.)

In support of his first argument, Plaintiff argues that the State Defendants placed the legal advice they received regarding the legality of the exclusion for gender reassignment surgery at issue by asserting it in their Responses to his First, Fourth, and Seventh Interrogatories, as well as during the depositions of former Director of ADOC Benefits Service Division Marie Isaacson and ADOA Plan Administration Manager Scott Bender. (*Id.* at 4-6.) Plaintiff's First Interrogatory asked Defendants to identify the

reasons why the Plan excludes coverage for gender reassignment surgery. (Doc. 195-3 at 30-31.) The State Defendants responded, in relevant part, that the Plan excludes gender reassignment surgery "because the State concluded, under the law, that it was not legally required" to provide such coverage. (Doc. 195-3 at 31.) Plaintiff's Fourth Interrogatory asked Defendants to identify all persons involved in making decisions related to the exclusion of gender reassignment surgery. (Doc. 195-3 at 33.) The State Defendants' Response identified three attorneys for the State; Plaintiff thus argues that the attorneys were central to the decision-making regarding the exclusion. (Doc. 195 at 5; Doc. 195-3 at 33). Plaintiff's Seventh Interrogatory asked Defendants to produce any documents that Defendants relied on relating to the exclusion. (Doc. 195-3 at 35.) The State Defendants' Response listed two memoranda—one from Marie Isaacson to Mike Liburdi, dated August 3, 2016 regarding "Affordable Care Act § 1557," and another from outside legal counsel Fennemore Craig, P.C. to Marie Isaacson dated July 20, 2016, regarding "Summary and Implications of § 1557 and Transgender Coverage Requirements"—both of which Defendants asserted were covered by the attorney-client privilege. (*Id*.) Marie Isaacson and Scott Bender testified during their depositions that the decision to exclude gender reassignment surgery from coverage under the Plan was based on what the Plan was legally required to cover. (Doc. 195-3 at 69, 79.) Plaintiff argues that these Interrogatory Responses and deposition testimony amount to an assertion of legal advice as a defense to his charge that the exclusion of coverage for gender reassignment surgery was motivated by discriminatory intent. (Doc. 195 at 5-6, 9-12.)

Next, Plaintiff argues that Defendants waived the attorney-client privilege by voluntarily disclosing the substance of the legal advice they received regarding the exclusion of gender reassignment surgery to the Governor's Office in 2016 and during the deposition of Marie Isaacson. (Doc. 195 at 7, 12-14; *see also* Doc. 195-3 at 57-58, 66.)

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III. Magistrate Judge Bowman's Order

In her Order granting Plaintiff's Motion to Compel ("the Order"), Magistrate Judge Bowman finds that the State Defendants implicitly waived the attorney-client privilege with respect to the withheld documents by relying upon the legal advice they received regarding exclusion of coverage for gender reassignment surgery as "evidence that they harbored no discriminatory intent" in maintaining the exclusion. (Doc. 213 at 1-2, 4.) The Order rejects Defendants' argument that they did not raise an "advice of counsel defense" as unsupported by the record, namely the Interrogatory Responses and deposition testimony discussed above. (*Id*. at 4-5.) The Order concludes that Plaintiff cannot realistically dispute Defendants' claimed reason for maintaining the exclusion of coverage for gender reassignment surgery without access to the legal advice that Defendants relied upon in making that decision, and that "fairness" thus mandates that Plaintiff be able to review the substance of that advice. (*Id*. at 5-6.) Because the Order finds that Defendants waived the attorney-client privilege by relying on the advice of legal counsel as a defense to the charge of discriminatory intent, it does not reach the merits of Plaintiff's alternate arguments involving witness deposition testimony or disclosure of the documents to the Governor's Office. (*Id.* at 2.)

IV. State Defendants' Appeal of the Order

On appeal, the State Defendants object to the Order on four grounds: (1) they did not assert or imply an "advice of counsel" defense through Interrogatory Responses or deposition testimony; (2) neither Marie Isaacson nor Scott Bender have authority to waive the attorney-client privilege; (3) compelling disclosure of the privileged documents violates public policy; and (4) the Order is unclear and ambiguous. (Doc. 223.)

First, the State Defendants argue that they never asserted—in their Answer, Interrogatory Responses, or deposition testimony—that they relied on the advice of counsel in deciding to maintain the Plan's exclusion of coverage for gender reassignment surgery, and that the Order "reads too much into" their Interrogatory Responses. (*Id*. at 1-6.) The State Defendants further contend that their Interrogatory Responses indicate that

they relied on non-privileged documents from "insurers and other entities" regarding the coverage exclusion. (*Id*. at 4.) Defendants further contend that because they never stated the parameters of the legal advice received or the degree to which they relied upon it, they did not put that legal advice at issue. (*Id*. at 5.)

Second, Defendants argue that the deposition testimony of Marie Isaacson and Scott Bender could not waive the attorney-client privilege because neither witness had the authority to speak on behalf of the State Defendants. (*Id*. at 6-7.) Third, Defendants argue that compelling production of the documents would violate public policy because State officials should be encouraged to consult with counsel in developing policies and thus allowing the State to engage in privileged communications with legal counsel is "uniquely important." (*Id*. at 7-8.)

Lastly, Defendants contend that the Order is "unclear and ambiguous" because it does not specify which documents it compelled Defendants to produce. (*Id*. at 8-10.) Defendants request that, if the Court affirms the Order, it compel production of only the attorney-client communications that relate to the legality of the exclusion and that were exchanged prior to the State's final decision to maintain the exclusion. (*Id*. at 9-10.)

V. Applicable Law

Issues of privilege in federal question cases are determined by federal law. Fed. R. Evid. 501. "The party asserting an evidentiary privilege has the burden to demonstrate that the privilege applies to the information in question." *Tornay v. United States*, 840 F.2d 1424, 1426 (9th Cir. 1988); *see also United States v. Ruehle*, 583 F.3d 600, 608 (9th Cir. 2009).

"The attorney-client privilege protects confidential communications between attorneys and clients, which are made for the purpose of giving legal advice." *United States v. Sanmina Corp.*, 968 F.3d 1107, 1116 (9th Cir. 2020). The Ninth Circuit employs an eight-part test to determine whether information is covered by the attorney-client privilege:

> (1) Where legal advice of any kind is sought (2) from a professional legal adviser in his capacity as such, (3) the communications relating to that purpose, (4) made in confidence (5) by the client, (6) are at his instance permanently protected (7) from disclosure by himself or by the legal adviser, (8) unless the protection be waived.

Id. (internal citation omitted). Here, the parties dispute only element (8), whether the privilege was waived. (*See* Doc. 213 at 3.)

Express waiver "occurs when a party discloses privileged information to a third party who is not bound by the privilege, or otherwise shows disregard for the privilege by making the information public." *Sanmina Corp.*, 968 F.3d at 1116-1117 (internal citation and quotation omitted). "In contrast, waiver by implication, or implied waiver, is based on the rule that a litigant waives the attorney-client privilege by putting the lawyer's performance at issue during the course of litigation." *Id*. at 1117. "Waivers by implication rest on the 'fairness principle,' which is often expressed in terms of preventing a party from using the privilege as both a shield and a sword." *Id*. (citing *Bittaker v. Woodford*, 331 F.3d 715, 719 (9th Cir. 2003)); *see also Chevron Corp. v. Pennzoil Co.*, 974 F.2d 1156, 1162 (9th Cir. 1992) ("The privilege which protects attorney-client communications may not be used both as a sword and a shield.")). "In practical terms, this means that parties in litigation may not abuse the privilege by asserting claims the opposing party cannot adequately dispute unless it has access to the privileged materials." *Sanmina Corp.*, 968 F.3d at 1117. Accordingly, "a holder of the attorney-client privilege or work-product immunity cannot claim that legal advice from his attorney justifies his actions while simultaneously shielding that advice from disclosure." *Melendres v. Arpaio*, No. CV-07-2513-PHX-GMS, 2015 WL 12911719, at *2 (D. Ariz. May 14, 2015).

"An implied waiver of the attorney-client privilege occurs when (1) the party asserts the privilege as a result of some affirmative act, such as filing suit; (2) through this affirmative act, the asserting party puts the privileged information at issue; and (3) allowing the privilege would deny the opposing party access to information vital to its

defense." *Home Indem. Co. v. Lane Powell Moss & Miller*, 43 F.3d 1322, 1326 (9th Cir. 1995) (citing *Hearn v. Rhay*, 68 F.R.D. 547, 581 (E.D. Wash. 1975)). "[A]n overarching consideration is whether allowing the privilege to protect against disclosure of the information would be manifestly unfair to the opposing party." *Id.* (internal quotation omitted).

VI. Analysis

The record supports affirming Magistrate Judge Bowman's Order compelling production of the withheld documents. The Court's review of the record reveals that, despite the State Defendants' protestations to the contrary, the State Defendants' Interrogatory Responses indicate that they relied on the advice of legal counsel in deciding to maintain the exclusion of coverage for gender reassignment surgery. (*See* Doc. 195-3 at 28-37.) This constitutes an affirmative act placing the privileged materials at issue. Furthermore, as Judge Bowman concluded, Plaintiff is unable to adequately respond to this defense without viewing the withheld documents. Without disclosure of the withheld documents, Plaintiff cannot fully respond to Defendants' argument that their reason for maintaining the exclusion was lawful and non-discriminatory because it was based on legal advice. As such, fairness mandates that the documents be disclosed. While the Court acknowledges that the public policy underlying the attorney-client privilege serves to protect the State's ability to engage in privileged communications with its lawyers, that interest does not overcome Plaintiff's right to fully litigate the merits of this action.

Accordingly,

IT IS ORDERED that Defendant's Appeal of the Order (Doc. 223) is **denied**.

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IT IS FURTHER ORDERED that Magistrate Judge Bowman's Order (Doc. 213) granting Plaintiff's Motion to Compel (Doc. 195) is **affirmed**. Within **fourteen (14) days** of the date of this Order, Defendants shall produce all documents related to Defendants' decision-making regarding the exclusion of coverage for gender reassignment surgery as requested in Plaintiff's Requests for Production One, Three, and Nine, including legal advice that may have informed that decision-making. Defendants need not produce documents that relate solely to their defense in the instant litigation.

Dated this 21st day of September, 2021.

Honorable Rosemary Márquez
United States District Judge

EXHIBIT 2

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

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

Defendants.

CV 19-0035-TUC-RM (LAB)

AMENDED COMPLAINT

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

JURISDICTION AND VENUE

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

10. This Court has jurisdiction pursuant to Article III of the United States Constitution; 28 U.S.C. §§ 1331, 1343; and 42 U.S.C. § 2000e-5(f)(3).

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

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

PARTIES

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

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

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

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

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

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

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

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

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

EXHAUSTION OF ADMINISTRATIVE REQUIREMENTS

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

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

FACTUAL ALLEGATIONS

Transgender individuals and gender dysphoria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

authorize coverage for the treatment.

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

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

Dr. Toomey's medically necessary treatment for gender dysphoria

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

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

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

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

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

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

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

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

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

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

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

(Ex. G at 1.)

CLASS ALLEGATIONS

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

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

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

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

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

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

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

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

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

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

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

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

56. Title VII of the Civil Rights Act of 1964 provides that employers may not "discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's . . . sex." 42 U.S.C. § 2000e-2(a)(l).

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

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

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

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

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

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

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

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

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

COUNT II
VIOLATION OF THE EQUAL PROTECTION CLAUSE

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

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

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

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

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

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

employees, including employees of the Arizona Board of Regents.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RELIEF REQUESTED

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

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

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

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

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

DATED this 2nd day of March, 2020.

ACLU FOUNDATION OF ARIZONA

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

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

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Wesley R. Powell*
Matthew S. Friemuth*
(**PRO HAC VICE* MOTION TO FOLLOW)

Attorneys for Plaintiff Russell B. Toomey

CERTIFICATE OF SERVICE

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

/s/ Christine K. Wee
Christine K. Wee

EXHIBIT A

ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

BENEFIT OPTIONS

Exclusive Provider Organization (EPO) Summary Plan Description

EFFECTIVE JANUARY 1, 2018

TABLE OF CONTENTS

ARTICLE 1

PLAN MODIFICATION, AMENDMENT AND TERMINATION

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

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

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

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

ARTICLE 2

ESTABLISHMENT OF PLAN

2.1 Purpose

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

2.2 Exclusive Benefit

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

2.3 Compliance

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

2.4 Legal Enforceability

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

2.5 Note to Members

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

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

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility

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

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

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

3.2 Member Eligibility

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

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

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

3.3 Continuing Eligibility through COBRA

See Section 3.13 of this article.

3.4 Non-COBRA Continuing Eligibility

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

Eligible Employee on Leave without Pay

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

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

- Completing 30 months of leave without pay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.5 Eligibility Audit

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

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

3.6 Grievances Related to Eligibility

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

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

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

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

3.7 Enrollment Procedures and Commencement of Coverage

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

3.8 Initial Enrollment

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

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

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

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

[1] Under no circumstance will coverage for a Dependent become effective prior to the Member's coverage becoming effective.
[2] For state employees entering retirement and their Dependents, coverage begins the first day of the first pay period following the end of coverage as a state employee. This results in no lapse in coverage.
[3] Eligibility is subject to A.R.S. § 38-802.

3.9 Open Enrollment

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

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

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

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

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

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

3.10 Qualified Life Event Enrollment

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

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

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

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

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

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

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

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

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

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

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

3.11 Change in Cost of Coverage

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

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

3.12 Termination of Coverage

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

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

[9] Excluding long-term disability recipient.

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

3.13 Continuing Eligibility through COBRA

Eligibility of Enrolled Members/Dependents

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

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

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

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

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

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

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

3.14 Subsequent Qualifying Events

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

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

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

3.15 Eligibility of Newly Acquired Eligible Dependents

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

3.16 Special Rules Regarding Disability

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

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

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

3.17 Payment for COBRA Coverage

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

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

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

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

3.18 Notification by the Member/Dependent

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

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

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

Written notification should be directed to:

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

3.19 Notification by the Plan

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

3.20 Electing COBRA Coverage

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

3.21 Early Termination of COBRA Coverage

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

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

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

3.22 Contact Information for the COBRA Administrator

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

3.23 Certificate of Creditable Coverage

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

ARTICLE 4

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

4.1 Pre-Certification/Prior Authorization and Notification

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

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

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

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

4.2 Treatment by Participating Providers

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

4.3 Treatment by Non-Participating Providers

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

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

4.4 Medical Services Inpatient Admissions

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

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

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

4.5 Other Services and Supplies

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

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

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

4.6 Notification of 23-Hour Observation Admissions

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

4.7 Notification of Maternity Services

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

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

4.8 Prescription Medications

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 5

CASE MANAGEMENT / DISEASE MANAGEMENT AND INDEPENDENT MEDICAL ASSESSMENT

5.1 Case Management

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

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

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

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

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

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

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

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

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

5.2 Disease Management

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

5.3 Independent Medical Assessment

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

ARTICLE 6

TRANSITION OF CARE

6.1 Transition of Care

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

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

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

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

ARTICLE 7

OPEN ACCESS TO PROVIDERS

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

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

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

ARTICLE 8

SCHEDULE OF MEDICAL BENEFITS
COVERED SERVICES AND SUPPLIES

8.1 Schedule of Medical Benefits Covered Services and Supplies Chart

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

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

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

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

8.2 Determination of Eligible Expenses

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

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

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

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

8.3 Out-of-Pocket Maximum for Participating Provider Expenses

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

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

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

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

8.4 Notification, Proof of a Claim, and Payment

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

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

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

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

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

8.5 Covered Expenses

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

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

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

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

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

8.6 Copayment

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

8.7 Autism Spectrum Disorder Services

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

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

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

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

8.8 Physician Services

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

8.9 Inpatient Hospital Services

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

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

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

8.10 Outpatient Facility Services

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

8.11 Emergency Services and Urgent Care

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

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

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

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

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

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

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

8.12 Continuing or Follow-up Treatment

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

8.13 Ambulance Service

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

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

8.14 Bariatric Surgery

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

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

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

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

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

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

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

The following bariatric procedures are excluded:

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

8.15 Breast Reconstruction and Breast Prostheses

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

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

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

8.16 Cancer Clinical Trials

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

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

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

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

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

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

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

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

8.17 Chiropractic Care Services

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

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

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

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

8.18 Cosmetic Surgery

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

8.19 Compression Garments

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

8.20 Dental Confinements/Anesthesia

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

8.21 Dental Services – Accident Only

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

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

8.22 Diabetic Service and Supplies

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

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

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

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

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

8.23 Diagnostic and Therapeutic Services

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

The following are examples of major diagnostic services:

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

The following are examples of minor diagnostic procedures:

- Laboratory services
- X-ray
- Ultrasounds
- Mammography

The following are examples of therapeutic procedures:

- Radiation therapy
- Chemotherapy
- Dialysis
- IV infusion therapy

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

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

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

8.24 Durable Medical Equipment

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

Durable medical equipment is defined as:

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

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

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

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

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

8.25 External Prosthetic Appliances

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

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

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

The following are specifically excluded:

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

8.26 Family Planning Services (Contraception and Voluntary Sterilization)

Covered family planning services including:

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

8.27 Foot Orthotics

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

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

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

8.28 Hearing Aids

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

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

8.29 Home Health Services

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

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

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

8.30 Hospice Services

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

Hospice care services do not include the following:

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

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

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

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

8.31 Immunizations

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

8.32 Infertility Services

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

8.33 Inpatient Services at Other Participating Health Care Facilities

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

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

8.34 Insulin Pumps and Supplies

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

8.35 Internal Prosthetic/Medical Appliances

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

8.36 Mammograms

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

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

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

8.37 Maternity Care Services

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

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

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

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

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

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

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

8.38 Medical Foods / Metabolic Supplements and Gastric Disorder Formula

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

Inherited metabolic disorders triggering medical food coverage are:

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

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

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

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

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

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

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

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

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

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

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

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

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

8.39 Medical Supplies

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

8.40 Mental Health and Substance Abuse Services

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

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

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

8.41 Inpatient Mental Health Services

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

8.42 Outpatient Mental Health Services

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

8.43 Outpatient Substance Abuse Rehabilitation Services

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

8.44 Mental Health and Substance Abuse Residential Treatment

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

8.45 Substance Abuse Detoxification Services

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

8.46 Excluded Mental Health and Substance Abuse Services

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

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

8.47 Nutritional Evaluation

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

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

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

8.48 Self-Management Training

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

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

8.49 Obstetrical and Gynecological Services

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

8.50 Organ Transplant Services

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

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

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

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

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

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

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

8.51 Organ Transplant Travel Services

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

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

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

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

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

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

8.52 Orthognathic Surgery

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

8.53 Ostomy Supplies

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

8.54 Oxygen and the Oxygen Delivery System

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

8.55 Preventive Care Services

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

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

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

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

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

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

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

8.56 Prostate Screening

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

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

8.57 Routine Physical

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

8.58 Radiation Therapy

Radiation therapy and other therapeutic radiological procedures are covered.

8.59 Short-Term Rehabilitative Therapy

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

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

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

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

3. Phase 3 cardiac rehabilitation is not covered.

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

8.60 Surgical Procedures – Multiple/Bilateral

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

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

8.61 Temporomandibular Joint (TMJ) Disorder

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

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

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

8.62 Well Child Health Examinations

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

8.63 Well Adult Examinations

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

ARTICLE 9

PRESCRIPTION DRUG BENEFITS

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

9.1 Prescription Drug Benefit

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

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

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

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

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

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

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

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

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

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

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

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

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

9.2 Covered Prescription Drugs

The term Covered Prescription Drugs means:

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

9.3 Limitations

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

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

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

9.4 Specialty Pharmacy

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

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

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

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

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

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

9.5 Reimbursement/Filing a Claim

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

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

9.6 Travel within the United States

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

9.7 International Travel

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

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

9.8 Extended Vacation

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

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

ARTICLE 10

EXCLUSIONS AND GENERAL LIMITATIONS

10.1 Exclusions and General Limitations

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

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

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

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

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

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

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

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

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

10.2 Circumstance Beyond the Plan's Control

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

ARTICLE 11

COORDINATION OF BENEFITS AND OTHER SOURCES OF PAYMENT

11.1 Coordination of Benefits and Other Sources of Payment

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

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

11.2 Workers' Compensation

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

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

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

11.3 Coordination of Benefits

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

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

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

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

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

11.4 Definitions

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

11.4.1. Plan

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

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

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

11.4.2. Closed Panel Plan

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

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

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

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

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

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

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

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

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

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

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

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

11.6 Effect on the Benefits of this Plan

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

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

For example:

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

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

11.7 Recovery of Excess Benefits

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

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

11.8 Right to Receive and Release Information

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

11.9 Injuries Covered under Med Pay Insurance

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

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

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

11.10 Subrogation and Right of Reimbursement Recovery

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

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

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

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

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

11.11 Statutory Liens

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

11.12 Fraud

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

ARTICLE 12

CLAIM FILING PROVISIONS AND APPEAL PROCESS

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

12.1 Discretionary Authority

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

12.2 Claims Filing Procedure

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

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

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

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

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

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

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

12.3 Notice of Claim – Post-Service Claims

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

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

12.4 Initial Claim Determination

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

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

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

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

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

12.5 Concurrent Care Decisions

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

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

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

12.6 Incomplete Urgent Care Claims Notification

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

12.7 Extensions of Time

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

12.8 Required Filing Procedures for Pre-Service Claims

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

12.9 Claims Appeal Procedures

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

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

b. Covered Employee's Member ID;
c. Name of the patient; and
d. Group/Client Identification number from the Member's ID card.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12.10 Levels of Standard Appeal and Responsibility of Review

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

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

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

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

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

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

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

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

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

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

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

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

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

12.11 Pharmacy Appeals

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

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

12.12 Limitation

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

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

ARTICLE 13

ADMINISTRATION

13.1 Plan Sponsor's Responsibilities

The Plan Sponsor shall have the authority and responsibility for:

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

13.2 Third Party Claim Administrator's Responsibilities

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

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

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

13.3 Advisors to Fiduciaries

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

13.4 Multiple Fiduciary Functions

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

13.5 Notice of Appointments or Delegations

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

13.6 Written Directions

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

13.7 Co-Fiduciary Liability

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

13.8 Action by Plan Sponsor

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

ARTICLE 14

LEGAL NOTICES

14.1 HIPAA Privacy Regulation Requirements

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

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

14.2 Notice of Special Enrollment Rights for Health Plan Coverage

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

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

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

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

14.3 Patient Protection & Affordable Care Act (PPACA) Notices

Notice of Rescission

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

Form W-2 Notice

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

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

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

Notice of Nondiscrimination

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

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

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

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

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

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

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

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভুক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខនៅលើកាតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID តំណាងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꮯ ᏏP ᎫCZᎮᏗ Ꮧ4ᏫᎠᏗ ᏂᎪᏯᏔW ᎥᏓ GᏙP ΛᎯ ᏏR ᎫJAΛᏗ ACᏫᎠΛᏗ ᎢᎾᏂᏫᎠᏗT, ᏯᎻ0ᵐᏫᎠᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga

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

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

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

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

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

14.4 General COBRA Notice

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

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

14.5 Women's Health and Cancer Rights Act Notice

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

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

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

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

14.6 Newborns' and Mothers' Protection Act of 1996 Notice

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

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

ARTICLE 15

MISCELLANEOUS

15.1 State Law

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

15.2 Status of Employment Relations

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

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

15.3 Word Usage

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

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

15.4 Titles are Reference Only

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

15.5 Clerical Error

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

ARTICLE 16

PLAN IDENTIFICATION

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

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

3. Third Party Claim Administrators:

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

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

4. Sponsor Identification Number: 86-6004791

5. Type of Benefits Provided: See Schedule of Benefits

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

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

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

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

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

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

ARTICLE 17

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

- Board Certified Behavior Analyst
- Board Certified Associate Behavior Analyst

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

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

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

AUTISM SPECTRUM DISORDER shall mean one of the three following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DEPENDENT see ELIGIBLE DEPENDENT.

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

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

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

EFFECTIVE DATE shall mean the first day of coverage.

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

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

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

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

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

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

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

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

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

EMPLOYEE see ELIGIBLE EMPLOYEE.

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

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

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

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

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

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

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

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

FOOT ORTHOTICS shall mean devices for support of the feet.

FORMER ELECTED OFFICIAL see ELIGIBLE FORMER ELECTED OFFICIAL

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

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL CONFINEMENT shall refer to a situation in which:

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

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

ILLNESS shall mean physical disease or sickness, including pregnancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTICIPANT shall mean a Member or a Dependent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RETIREE see ELIGIBLE RETIREE.

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

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

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

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

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

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

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

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

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

SUBSTANCE ABUSE shall mean:

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

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

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

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

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

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

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

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

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

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

TIMELY FILING shall mean within one year after the date a service is rendered.

URGENT CARE FACILITY shall mean a facility other than a free clinic providing medical care and treatment of sick or injured persons on an outpatient basis. In addition, it must meet all of the following tests:

1. Is accredited by the Joint Commission on Accreditation of Hospitals, or be approved by the federal government to participate in federal and state programs;
2. Maintains on-premise diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified physicians;
3. Is operated continuously with organized facilities for minor operative surgery on the premises;
4. Has continuous physician services and registered professional nursing services whenever a patient visits the facility; and
5. Does not provide services or other accommodations for patients to stay overnight.

VARIABLE HOUR EMPLOYEE shall mean an individual employed by the state, if based on the facts and circumstances at the Employee's start date, for whom the state cannot determine whether the Employee is reasonably expected to be employed an average of at least 30 hours per week, including any paid leave, over the applicable 12-month measurement period because the Employee's hours are variable or otherwise uncertain.

EXHIBIT B

U.S. Department of Justice
Civil Rights Division
NOTICE OF RIGHT TO SUE WITHIN 90 DAYS

CERTIFIED MAIL
7003 0500 0002 5072 0599

950 Pennsylvania Avenue, N.W.
Karen Ferguson , EMP, PHB, Room 4701
Washington, DC 20530

December 14, 2018

Mr. Russell Toomey, PhD
c/o James Burr Shields, Esquire
Law Offices of Aiken & Schenk
2390 E. Camelback Rd.
Suite 400
Phoenix, AZ 85016

DEC 27 2018

Re: EEOC Charge Against Board of Regents of the University of Arizona
No. 540201804629

Dear Mr. Toomey, PhD:

Because you filed the above charge with the Equal Employment Opportunity Commission, and the Commission has determined that it will not be able to investigate and conciliate that charge within 180 days of the date the Commission assumed jurisdiction over the charge and the Department has determined that it will not file any lawsuit(s) based thereon within that time, and because you through your attorney have specifically requested this Notice, you are hereby notified that you have the right to institute a civil action under Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000e, et seq., against the above-named respondent.

If you choose to commence a civil action, such suit must be filed in the appropriate Court within 90 days of your receipt of this Notice.

The investigative file pertaining to your case is located in the EEOC Phoenix District Office, Phoenix, AZ.

This Notice should not be taken to mean that the Department of Justice has made a judgment as to whether or not your case is meritorious.

Sincerely,

Eric S. Dreiband
Assistant Attorney General
Civil Rights Division

by Karen L. Ferguson
Karen L. Ferguson
Supervisory Civil Rights Analyst
Employment Litigation Section

cc: Phoenix District Office, EEOC
Board of Regents of the University of Arizona

EXHIBIT C

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(https://www.aetna.com/)

Gender Reassignment Surgery

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Number: 0615

Policy

Aetna considers gender reassignment surgery medically necessary when all of the following criteria are met:

I. Requirements for mastectomy for female-to-male patients:

A. Single letter of referral from a qualified mental health professional (see Appendix); *and*
B. Persistent, well-documented gender dysphoria (see Appendix); *and*
C. Capacity to make a fully informed decision and to consent for treatment; *and*
D. For members below the age of majority (less than 18 years of age), completion of one year of testosterone treatment; *and*
E. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy in adults.

II. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):

Policy History

Last Review

09/09/2019

Effective: 05/14/2002

Next Review: 06/26/2020

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes

A. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); *and*
B. Persistent, well-documented gender dysphoria (see Appendix); *and*
C. Capacity to make a fully informed decision and to consent for treatment; *and*
D. Age of majority (18 years or older); *and*
E. If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)

III. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female)

A. Two referral letters from qualified mental health professionals, one in a purely evaluative role (see appendix); *and*
B. Persistent, well-documented gender dysphoria (see Appendix); *and*
C. Capacity to make a fully informed decision and to consent for treatment; *and*
D. Age of majority (age 18 years and older); *and*
E. If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); *and*
G. Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

Note: Blepharoplasty, body contouring (liposuction of the waist), breast enlargement procedures such as augmentation mammoplasty and implants, face-lifting, facial bone reduction, feminization of torso, hair removal, lip enhancement, reduction thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization, are considered cosmetic. Similarly, chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization, are considered cosmetic.

Note on gender specific services for the transgender community

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male trans identified persons who have not undergone a mastectomy;
2. Prostate cancer screening may be medically necessary for male to female trans identified persons who have retained their prostate.

Aetna considers gonadotropin-releasing hormone medically necessary to suppress puberty in trans identified adolescents if they meet World Professional Association for Transgender Health (WPATH) criteria (see CPB 0501 - Gonadotropin-Releasing Hormone Analogs and Antagonists (../500_599/0501.html)).

Aetna considers the following procedures that may be performed as a component of a gender reassignment as cosmetic (not an all-inclusive list) (see also CPB 0031 - Cosmetic Surgery (../1_99/0031.html)):

- Abdominoplasty
- Blepharoplasty
- Brow lift
- Calf implants
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Construction of a clitoral hood
- Drugs for hair loss or growth
- Facial feminization and masculinization surgery
- Forehead lift
- Jaw reduction (jaw contouring)
- Hair removal (e.g., electrolysis, laser hair removal)
- Hair transplantation
- Lip reduction
- Liposuction

- Mastopexy
- Neck tightening
- Nipple reconstruction
- Nose implants
- Pectoral implants
- Pitch-raising surgery
- Removal of redundant skin
- Rhinoplasty
- Tracheal shave
- Voice therapy/voice lessons.

Background

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between an individual's gender identity and the gender assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). A diagnosis of gender dysphoria requires a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. This condition may cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender reassignment surgery is performed to change primary and/or secondary sex characteristics. For male to female gender reassignment, surgical procedures may include genital reconstruction (vaginoplasty, penectomy, orchidectomy, clitoroplasty) and cosmetic surgery (breast implants, facial reshaping, rhinoplasty, abdominoplasty, thyroid chondroplasty (laryngeal shaving), voice modification surgery (vocal cord shortening), hair transplants) (Day, 2002). For female to male gender reassignment, surgical procedures may include mastectomy, genital reconstruction (phalloplasty, genitoplasty, hysterectomy, bilateral oophorectomy), mastectomy, and cosmetic procedures to enhance male features such as pectoral implants and chest wall recontouring (Day, 2002).

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery (Coleman, et al., 2011).

In addition to hormone therapy and gender reassignment surgery, psychological adjustments are necessary in affirming sex. Treatment should focus on psychological adjustment, with hormone therapy and gender reassignment surgery being viewed as confirmatory procedures dependent on adequate psychological adjustment. Mental health care may need to be continued after gender reassignment surgery. The overall success of treatment depends partly on the technical success of the surgery, but more crucially on the psychological adjustment of the trans identified person and the support from family, friends, employers and the medical profession.

Nakatsuka (2012) noted that the 3rd versions of the guideline for treatment of people with gender dysphoria (GD) of the Japanese Society of Psychiatry and Neurology recommends that feminizing/masculinizing hormone therapy and genital surgery should not be carried out until 18 years old and 20 years old, respectively. On the other hand, the 6th (2001) and the 7th (2011) versions of the standards of care for the health of transsexual, transgender, and gender non-conforming people of World Professional Association for Transgender Health (WPATH) recommend that transgender adolescents (Tanner stage 2, [mainly 12 to 13 years of age]) are treated by the endocrinologists to suppress puberty with gonadotropin-releasing hormone (GnRH) agonists until age 16 years old, after which cross-sex hormones may be given. A questionnaire on 181 people with GID diagnosed in the Okayama University Hospital (Japan) showed that female to male (FTM) trans identified individuals hoped to begin masculinizing hormone therapy at age of 15.6 +/- 4.0 (mean +/- S.D.) whereas male to female (MTF) trans identified individuals hoped to begin feminizing hormone therapy as early as age 12.5 +/- 4.0, before presenting secondary sex characters. After confirmation of strong and persistent trans gender identification, adolescents with GD should be treated with cross-gender hormone or puberty-delaying hormone to prevent developing undesired sex characters. These treatments may prevent transgender adolescents from attempting suicide, suffering from depression, and refusing to attend school.

Spack (2013) stated that GD is poorly understood from both mechanistic and clinical standpoints. Awareness of the condition appears to be increasing, probably because of greater societal acceptance and available hormonal treatment. Therapeutic options include hormone and surgical treatments but may be limited by insurance coverage because costs are high. For patients seeking MTF affirmation, hormone treatment includes estrogens, finasteride, spironolactone, and GnRH analogs. Surgical options include feminizing genital and facial surgery, breast augmentation, and various fat transplantations. For patients seeking a FTM gender affirmation, medical therapy includes testosterone and GnRH analogs and surgical

therapy includes mammoplasty and phalloplasty. Medical therapy for both FTM and MTF can be started in early puberty, although long-term effects are not known. All patients considering treatment need counseling and medical monitoring.

Leinung and colleagues (2013) noted that the Endocrine Society's recently published clinical practice guidelines for the treatment of transgender persons acknowledged the need for further information on transgender health. These investigators reported the experience of one provider with the endocrine treatment of transgender persons over the past 2 decades. Data on demographics, clinical response to treatment, and psychosocial status were collected on all transgender persons receiving cross-sex hormone therapy since 1991 at the endocrinology clinic at Albany Medical Center, a tertiary care referral center serving upstate New York. Through 2009, a total 192 MTF and 50 FTM transgender persons were seen. These patients had a high prevalence of mental health and psychiatric problems (over 50 %), with low rates of employment and high levels of disability. Mental health and psychiatric problems were inversely correlated with age at presentation. The prevalence of gender reassignment surgery was low (31 % for MTF). The number of persons seeking treatment has increased substantially in recent years. Cross-sex hormone therapy achieves very good results in FTM persons and is most successful in MTF persons when initiated at younger ages. The authors concluded that transgender persons seeking hormonal therapy are being seen with increasing frequency. The dysphoria present in many transgender persons is associated with significant mood disorders that interfere with successful careers. They stated that starting therapy at an earlier age may lessen the negative impact on mental health and lead to improved social outcomes.

Meyer-Bahlburg (2013) summarized for the practicing endocrinologist the current literature on the psychobiology of the development of gender identity and its variants in individuals with disorders of sex development or with transgenderism. Gender reassignment remains the treatment of choice for strong and persistent gender dysphoria in both categories, but more research is needed on the short-term and long-term effects of puberty-suppressing medications and cross-sex hormones on brain and behavior.

Irreversible Surgical Interventions for Minors

The World Professional Association for Transgender Health (WPATH) recommendations version 7 (Coleman, et al., 2011) states, regarding irreversible surgical interventions, that " [g]enital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention." The WPATH guidelines

state that "Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression."

Note on Nipple Reconstruction

Aetna considers nipple reconstruction, as defined by the American Medical Association (AMA) Current Procedural Terminology (CPT) code 19350, cosmetic/not medically necessary for mastectomy for female to male gender reassignment. Performance of a mastectomy for gender reassignment does not involve a nipple reconstruction as defined by CPT code 19350.

Some have cited breast reconstruction surgery for breast cancer, i.e., recreation of a breast after mastectomy, as support for coverage of nipple reconstruction. Mastectomy for female to male gender reassignment surgery, however, involves mastectomy without restoration of the breast. There are important differences between a mastectomy for breast cancer and a mastectomy for gender reassignment. The former requires careful attention to removal of all breast tissue to reduce the risk of cancer. By contrast, careful removal of all breast tissue is not essential in mastectomy for gender reassignment.

In mastectomy for gender reassignment, the nipple areola complex typically can be preserved. There is no routine indication for nipple reconstruction as defined by CPT code 19350, the exceptions being unusual cases where construction of a new nipple may be necessary in persons with very large and ptotic breasts. See, e.g., Bowman, et al., 2006).

Some have justified routinely billing CPT code 19350 for nipple reconstruction code for mastectomy for gender reassignment based upon the frequent need to reduce the size of the areola to give it a male appearance. However, the nipple reconstruction as defined by CPT code 19350 describes a much more involved procedure than areola reduction. The typical patient vignette for CPT code 19350, according to the AMA, is as follows: "The patient is measured in the standing position to ensure even balanced position for a location of the nipple and areola graft on the right breast. Under local anesthesia, a Skate flap is elevated at the site selected for the nipple reconstruction and constructed. A full-thickness skin graft is taken from the right groin to reconstruct the areola. The right groin donor site is closed primarily in layers."

Aetna will consider allowing modifier -22 to be appended to the mastectomy CPT code when this procedure is performed for gender reassignment to allow additional reimbursement for the extra work that may be necessary to reshape the nipple and create an aesthetically pleasing male chest. CPT code 19350 does not describe the work that that is being done, because that code describes the actual construction of a new nipple. The CPT defines modifier 22 as "Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)."

Thus, Aetna considers nipple reconstruction, as defined by CPT code 19350, as cosmetic/not medically necessary for mastectomy for female to male gender reassignment, and that appending modifier 22 to the mastectomy code would more accurately reflect the extra work that may typically be necessary to obtain an aesthetically pleasing result.

Vulvoplasty versus Vaginoplasty as Gender-Affirming Genital Surgery for Transgender Women

Jiang and colleagues (2018) noted that gender-affirming vaginoplasty aims to create the external female genitalia (vulva) as well as the internal vaginal canal; however, not all patients desire nor can safely undergo vaginal canal creation. These investigators described the factors influencing patient choice or surgeon recommendation of vulvoplasty (creation of the external appearance of female genitalia without creation of a neovaginal canal) and evaluated the patient's satisfaction with this choice. Gender-affirming genital surgery consults were reviewed from March 2015 until December 2017, and patients scheduled for or who had completed vulvoplasty were interviewed by telephone. These investigators reported demographic data and the reasons for choosing vulvoplasty as gender-affirming surgery for patients who either completed or were scheduled for surgery, in addition to patient reports of satisfaction with choice of surgery, satisfaction with the surgery itself, and sexual activity after surgery. A total of 486 patients were seen in consultation for trans-feminine gender-affirming genital surgery: 396 requested vaginoplasty and 39 patients requested vulvoplasty; 30 Patients either completed or are scheduled for vulvoplasty. Vulvoplasty patients were older and had higher body mass index (BMI) than those seeking vaginoplasty. The majority (63 %) of the patients seeking vulvoplasty chose this surgery despite no contraindications to vaginoplasty. The remaining patients had risk factors leading the surgeon to recommend vulvoplasty. Of those who completed surgery, 93 % were satisfied with the surgery and their decision for vulvoplasty. The authors concluded

that this was the first study of factors impacting a patient's choice of or a surgeon's recommendation for vulvoplasty over vaginoplasty as gender-affirming genital surgery; it also was the first reported series of patients undergoing vulvoplasty only.

Drawbacks of this study included its retrospective nature, non-validated questions, short-term follow-up, and selection bias in how vulvoplasty was offered. Vulvoplasty is a form of gender-affirming feminizing surgery that does not involve creation of a neovagina, and it is associated with high satisfaction and low decision regret.

Autologous Fibroblast-Seeded Amnion for Reconstruction of Neo-vagina in Male-to-Female Reassignment Surgery

Seyed-Forootan and colleagues (2018) stated that plastic surgeons have used several methods for the construction of neo-vaginas, including the utilization of penile skin, free skin grafts, small bowel or recto-sigmoid grafts, an amnion graft, and cultured cells. These researchers compared the results of amnion grafts with amnion seeded with autograft fibroblasts. Over 8 years, these investigators compared the results of 24 male-to-female transsexual patients retrospectively based on their complications and levels of satisfaction; 16 patients in group A received amnion grafts with fibroblasts, and the patients in group B received only amnion grafts without any additional cellular lining. The depths, sizes, secretions, and sensations of the vaginas were evaluated. The patients were monitored for any complications, including over-secretion, stenosis, stricture, fistula formation, infection, and bleeding. The mean age of group A was 28 ± 4 years and group B was 32 ± 3 years. Patients were followed-up from 30 months to 8 years (mean of 36 ± 4) after surgery. The depth of the vaginas for group A was 14 to 16 and 13 to 16 cm for group B. There was no stenosis in neither group. The diameter of the vaginal opening was 34 to 38 mm in group A and 33 to 38 cm in group B. These researchers only had 2 cases of stricture in the neo-vagina in group B, but no stricture was recorded for group A. All of the patients had good and acceptable sensation in the neo-vagina; 75 % of patients had sexual experience and of those, 93.7 % in group A and 87.5% in group B expressed satisfaction. The authors concluded that the creation of a neo-vaginal canal and its lining with allograft amnion and seeded autologous fibroblasts is an effective method for imitating a normal vagina. The size of neo-vagina, secretion, sensation, and orgasm was good and proper. More than 93.7 % of patients had satisfaction with sexual intercourse. They stated that amnion seeded with fibroblasts extracted from the patient's own cells will result in a vagina with the proper size and moisture that can eliminate the need for long-term dilatation. The constructed vagina has a 2-layer structure and is much more resistant to trauma and laceration. No cases of stenosis or stricture were recorded. Level of Evidence = IV. These preliminary findings need to be validated by well-designed studies.

Pitch-Raising Surgery in Male-to-Female Transsexuals

Van Damme and colleagues (2017) reviewed the evidence of the effectiveness of pitch-raising surgery performed in male-to-female transsexuals. These investigators carried out a search for studies in PubMed, Web of Science, Science Direct, EBSCOhost, Google Scholar, and the references in retrieved manuscripts, using as keywords "transsexual" or "transgender" combined with terms related to voice surgery. They included 8 studies using cricothyroid approximation, 6 studies using anterior glottal web formation, and 6 studies using other surgery types or a combination of surgical techniques, leading to 20 studies in total. Objectively, a substantial rise in post-operative fundamental frequency was identified. Perceptually, mainly laryngeal web formation appeared risky for decreasing voice quality. The majority of patients appeared satisfied with the outcome. However, none of the studies used a control group and randomization process. The authors concluded that future research needs to investigate long-term effects of pitch-raising surgery using a stronger study design.

Azul and associates (2017) evaluated the currently available discursive and empirical data relating to those aspects of trans-masculine people's vocal situations that are not primarily gender-related, and identified restrictions to voice function that have been observed in this population, and made suggestions for future voice research and clinical practice. These researchers conducted a comprehensive review of the voice literature. Publications were identified by searching 6 electronic databases and bibliographies of relevant articles. A total of 22 publications met inclusion criteria. Discourses and empirical data were analyzed for factors and practices that impact on voice function and for indications of voice function-related problems in trans-masculine people. The quality of the evidence was appraised. The extent and quality of studies investigating trans-masculine people's voice function was found to be limited. There was mixed evidence to suggest that trans-masculine people might experience restrictions to a range of domains of voice function, including vocal power, vocal control/stability, glottal function, pitch range/variability, vocal endurance, and voice quality. The authors concluded that more research into the different factors and practices affecting trans-masculine people's voice function that took account of a range of parameters of voice function and considered participants' self-evaluations is needed to establish how functional voice production can be best supported in this population.

Facial Feminization Surgery

Raffaini and colleagues (2016) stated that gender dysphoria refers to the discomfort and distress that arise from a discrepancy between a person's gender identity and sex assigned at birth. The treatment plan for gender dysphoria varies and can include psychotherapy, hormone

treatment, and gender reassignment surgery, which is, in part, an irreversible change of sexual identity. Procedures for transformation to the female sex include facial feminization surgery, vaginoplasty, clitoroplasty, and breast augmentation. Facial feminization surgery can include forehead re-modeling, rhinoplasty, mentoplasty, thyroid chondroplasty, and voice alteration procedures. These investigators reported patient satisfaction following facial feminization surgery, including outcome measurements after forehead slippage and chin re-modeling. A total of 33 patients between 19 and 40 years of age were referred for facial feminization surgery between January of 2003 and December of 2013, for a total of 180 procedures. Surgical outcome was analyzed both subjectively through questionnaires administered to patients and objectively by serial photographs. Most facial feminization surgery procedures could be safely completed in 6 months, barring complications. All patients showed excellent cosmetic results and were satisfied with their procedures. Both frontal and profile views achieved a loss of masculine features. The authors concluded that patient satisfaction following facial feminization surgery was high; they stated that the reduction of gender dysphoria had psychological and social benefits and significantly affected patient outcome. Leve of Evidence = IV.

Morrison and associates (2018) noted that facial feminization surgery encompasses a broad range of cranio-maxillofacial surgical procedures designed to change masculine facial features into feminine features. The surgical principles of facial feminization surgery could be applied to male-to-female transsexuals and anyone desiring feminization of the face. Although the prevalence of these procedures is difficult to quantify, because of the rising prevalence of transgenderism (approximately 1 in 14,000 men) along with improved insurance coverage for gender-confirming surgery, surgeons versed in techniques, outcomes, and challenges of facial feminization surgery are needed. These researchers appraised the current facial feminization surgery literature. They carried out a comprehensive literature search of the Medline, PubMed, and Embase databases was conducted for studies published through October 2014 with multiple search terms related to facial feminization. Data on techniques, outcomes, complications, and patient satisfaction were collected. A total of 15 articles were selected and reviewed from the 24 identified, all of which were either retrospective or case series/reports. Articles covered a variety of facial feminization procedures. A total of 1,121 patients underwent facial feminization surgery, with 7 complications reported, although many articles did not explicitly comment on complications. Satisfaction was high, although most studies did not use validated or quantified approaches to address satisfaction. The authors concluded that facial feminization surgery appeared to be safe and satisfactory for patients. These researchers

stated that further studies are needed to better compare different techniques to more robustly establish best practices; prospective studies and patient-reported outcomes are needed to establish quality-of-life (QOL) outcomes for patients.

Appendix

DSM 5 Criteria for Gender Dysphoria in Adults and Adolescents

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by two or more of the following:

I. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)
II. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
III. A strong desire for the primary and/or secondary sex characteristics of the other gender
IV. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
V. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
VI. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

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

Format for referral letters from Qualified Health Professional: (From SOC-7)

I. Client's general identifying characteristics; *and*
II. Results of the client's psychosocial assessment, including any diagnoses; *and*
III. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date; *and*

IV. An explanation that the WPATH criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery; *and*
V. A statement about the fact that informed consent has been obtained from the patient; *and*
VI. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

Note: There is no minimum duration of relationship required with mental health professional. It is the professional's judgment as to the appropriate length of time before a referral letter can appropriately be written. A common period of time is three months, but there is significant variation in both directions. When two letters are required, the second referral is intended to be an evaluative consultation, not a representation of an ongoing long-term therapeutic relationship, and can be written by a medical practitioner of sufficient experience with gender dysphoria.

Note: Evaluation of candidacy for sex reassignment surgery by a mental health professional is covered under the member's medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the member's behavioral health benefit. Please check benefit plan descriptions.

Characteristics of a Qualified Mental Health Professional: (From SOC-7)

I. Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board. The professional should also have documented credentials from the relevant licensing board or equivalent; *and*
II. Competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes; *and*
III. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; *and*
IV. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; *and*
V. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

Code	Code Description
CPT codes covered if selection criteria are met:	
19301, 19303 - 19304	Mastectomy
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400 - 54417	Penile prosthesis
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopic, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	complicated
55970	Intersex surgery; male to female [a series of staged procedures that includes male genitalia removal, penile dissection, urethral transposition, creation of vagina and labia with stent placement]
55980	female to male [a series of staged procedures that include penis and scrotum formation by graft, and prostheses placement]
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure)
57106 - 57107, 57110 - 57111	Vaginectomy
57291 - 57292	Construction of artificial vagina
57335	Vaginoplasty for intersex state

Code	Code Description
58150, 58180, 58260 - 58262, 58275 - 58291, 58541 - 58544, 58550 - 58554	Hysterectomy
58570 - 58573	Laparoscopy, surgical, with total hysterectomy
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral
CPT codes not covered for indications listed in the CPB [considered cosmetic]:	
Tracheal shave - no specific code:	
11950 - 11954	Subcutaneous injection of filling material (e.g., collagen)
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less [nipple reconstruction]
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780 - 15787	Dermabrasion
15788 - 15793	Chemical peel
15820 - 15823	Blepharoplasty
15824 - 15828	Rhytidectomy [face-lifting]
15830 - 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15876 - 15879	Suction assisted lipectomy
17380	Electrolysis epilation, each 30 minutes
19316	Mastopexy
19318	Reduction mammaplasty
19324 - 19325	Mammaplasty, augmentation
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

Code	Code Description
19350	Nipple/areola reconstruction
21087	Nasal prosthesis
21120 - 21123	Genioplasty
21125 - 21127	Augmentation, mandibular body or angle; prosthetic material or with bone graft, onlay or interpositional (includes obtaining autograft)
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21194	with bone graft (includes obtaining graft)
21195	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
21196	with internal rigid fixation
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400 - 30420	Rhinoplasty; primary
30430 - 30450	Rhinoplasty; secondary
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals
Other CPT codes related to the CPB:	
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
+90785	Interactive complexity (List separately in addition to the code for primary procedure)
90832 - 90838	Psychotherapy
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance of drug); subcutaneous or intramuscular
HCPCS codes covered if selection criteria are met:	
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable

Code	Code Description
J1071	Injection, testosterone cypionate, 1 mg
J3121	Injection, testosterone enanthate, 1 mg
J3145	Injection, testosterone undecanoate, 1 mg
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J9202	Goserelin acetate implant, per 3.6 mg
J9217	Leuprolide acetate (for depot suspension), 7.5 mg
J9218	Leuprolide acetate, per 1 mg
J9219	Leuprolide acetate implant, 65 mg
S0189	Testosterone pellet, 75 mg
HCPCS codes not covered for indications listed in the CPB :	
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
S9128	Speech therapy, in the home, per diem
ICD-10 codes covered if selection criteria are met:	
F64.0 - F64.1	Transexualism and dual role transvestism
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment
ICD-10 codes not covered for indications listed in the CPB:	
F64.2	Gender identity disorder of childhood

The above policy is based on the following references:

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EXHIBIT D

BlueCross BlueShield of Arizona
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MEDICAL COVERAGE GUIDELINES
SECTION: MEDICINE

ORIGINAL EFFECTIVE DATE: 06/20/17
LAST REVIEW DATE: 09/04/18
LAST CRITERIA REVISION DATE: 08/21/18
ARCHIVE DATE:

TREATMENTS FOR GENDER DYSPHORIA

Non-Discrimination Statement and Multi-Language Interpreter Services information are located at the end of this document.

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Medical Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Description:

Gender dysphoria refers to the discomfort or distress caused by discrepancy between an individual's gender identity and the gender assigned at birth.

1. Treatments for gender dysphoria include:
   - Medical treatment
   - Hormone therapy(routes of administration include buccal tablets, intramuscular injections, oral medication, topical gel and topical patches)
   - Psychotherapy

2. Surgical procedures to change primary and secondary sex characteristics (i.e., breast/chest, genitalia). Surgery, particularly genital surgery, is often the last and the most considered step in the treatment process for gender dysphoria.

Female-to-Male (FTM) Surgical Procedures

Breast/Chest Surgery	Genital Surgery
Subcutaneous mastectomy	Hysterectomy/salpingo-oophorectomy
Chest reconstruction in conjunction with bilateral mastectomy	Implantation of penile erection and/or testicular prostheses
	Metoidioplasty or phalloplasty
	Scrotoplasty
	Urethroplasty
	Vaginectomy

Male-to-Female (MTF) Surgical Procedures

Breast/Chest Surgery	Genital Surgery
Augmentation mammoplasty (implants/lipofilling)	Clitoroplasty
	Orchiectomy
	Penectomy
	Urethroplasty
	Vaginoplasty
	Vulvoplasty

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	LAST CRITERIA REVISION DATE:	08/21/18
	ARCHIVE DATE:	

TREATMENTS FOR GENDER DYSPHORIA (cont.)

Description: (cont.)

Referral for Surgery:
Surgical treatments for gender dysphoria are initiated by a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation, in the chart and/or referral letter, of the individual's personal and treatment history, progress and eligibility.

Breast surgery requires one referral from a qualified mental health professional.

Genital surgery requires two referrals from qualified mental health professionals. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of referral letters for surgery is as follows:

1. General identifying characteristics
2. Psychosocial assessment results, including diagnoses
3. Duration of the mental health professional's relationship with the individual, including the type of evaluation and therapy or counseling to date
4. Explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the surgery request
5. Statement that informed consent has been obtained from the individual seeking surgery
6. Statement that the mental health professional is available for coordination of care.

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MEDICAL COVERAGE GUIDELINES
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ORIGINAL EFFECTIVE DATE: 06/20/17
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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Definitions:

Cosmetic:
Surgery, procedures or treatment and other services performed primarily to enhance or improve appearance, including *but not limited to*, those surgeries, procedures, treatments and other services performed in the absence of a functional impairment of a body part or organ as documented in the medical record, even if such services will improve emotional, psychological or mental condition.

Liposuction and lipofilling of the chest, waist, hips and buttocks are cosmetic contouring procedures to feminize or masculinize the body. FTM chest contouring produces a masculine V-shaped torso. MTF contouring produces feminine features such as a curvier waist and fuller hips and buttocks.

FTM facial masculinization procedures include *but are not limited to*: forehead lengthening and augmentation, chin, cheek and jaw augmentation, hair transplant, rhinoplasty/nasal augmentation and thyroid cartilage/Adam's Apple enhancement.

MTF facial feminization procedures include *but are not limited to*: brow lift, cheek implants/enhancement, chin and jaw contouring, forehead reduction/contouring, hairline advancement, lip augmentation, rhinoplasty and thyroid cartilage/Adam's Apple reduction.

Gender Reassignment Surgery:
Surgery to change primary and/or secondary sex characteristics to affirm an individual's gender identity. Sex or gender reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria. May also be known as gender or transgender transition surgery.

Hormone Therapy for Adolescents:
Endocrine Society Clinical Practice Guidelines for endocrine treatment of transsexual persons state that adolescents are eligible and ready for gonadotropin-releasing hormone (GnRH) therapy for suppression of puberty if they:

1. Fulfill DSM IV-TR or ICD-10 criteria for gender identity disorder (GID) or transsexualism
2. Have experienced puberty to at least Tanner stage 2
3. Have (early) pubertal changes that have resulted in an increase of their gender dysphoria
4. Do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment
5. Have adequate psychological and social support during treatment
6. Demonstrate knowledge and understanding of the expected outcomes of GnRH analog treatment, cross-sex hormone treatment, and sex reassignment surgery, as well as the medical and the social risks and benefits of sex reassignment

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Definitions: (cont.)

Transgender:
Describes a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth.

Transition:
Transition is the period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition are variable and individualized.

Suppression of puberty using hormone therapy is not considered transition.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria:

COVERAGE FOR GENDER DYSPHORIA TREAMENT IS DEPENDENT UPON BENEFIT PLAN LANGUAGE. REFER TO MEMBER'S SPECIFIC BENEFIT PLAN BOOKLET TO VERIFY BENEFITS.

If benefit coverage for gender dysphoria treatment is available, requests for gender dysphoria treatment will be reviewed by the medical director(s) and/or clinical advisor(s).

Medical Treatment for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available**, the following medical treatments are considered ***medically necessary***:

  1. Female-to-male hormone therapy[1]
  2. Male-to-female hormone therapy[1]
  3. Psychotherapy

- **If benefit coverage for gender dysphoria treatment is available,** subcutaneous hormone pellet implants are considered ***experimental or investigational*** based upon:

  1. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  2. Insufficient evidence to support improvement of the net health outcome, and
  3. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives.

  These indications include, *but are not limited to:*

  - Female-to-male hormone therapy
  - Male-to-female hormone therapy

- **If benefit coverage for gender dysphoria treatment is not available**, gender dysphoria medical treatment is considered ***a benefit plan exclusion*** and ***not eligible for coverage.***

[1] Includes buccal tablets, intramuscular injections, oral medication, topical gel and topical patches.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Female-to-Male:

Surgical Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** the following surgical procedures are considered ***eligible for coverage***:

1. Mastectomy with documentation of **ALL** of the following:

   - One referral from qualified mental health professional
   - Persistent, well-documented gender dysphoria
   - Capacity to make a fully informed decision and to give consent for treatment
   - Age of majority in a given country (if younger, follow the standards of care for children and adolescents)
   - If significant medical or mental health concerns are present, they must be reasonably well controlled

Hormone therapy is not a prerequisite.

2. Hysterectomy/salpingo-oophorectomy with documentation of **ALL** of the following:

   - Two referrals from qualified mental health professionals
   - Persistent, well documented gender dysphoria
   - Capacity to make a fully informed decision and to give consent for treatment
   - Age of majority in a given country
   - If significant medical or mental health concerns are present, they must be well controlled
   - 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless hormones are not clinically indicated for the individual)

These criteria do not apply to individuals having these surgical procedures for medical indications other than gender dysphoria.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Female-to-Male: (cont.)

Surgical Procedures for Gender Dysphoria: (cont.)

- **If benefit coverage for gender dysphoria treatment is available,** the following surgical procedures are considered ***eligible for coverage***: (cont.)

  3. Scrotoplasty, implantation of penile erection and/or testicular prostheses, metoidioplasty or phalloplasty, urethroplasty and vaginectomy with documentation of **ALL** of the following:

     - Two referrals from qualified mental health professionals
     - Persistent, well documented gender dysphoria
     - Capacity to make a fully informed decision and to consent for treatment
     - Age of majority in a given country
     - If significant medical or mental health concerns are present, they must be well controlled
     - 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless hormones are not clinically indicated for the individual)
     - 12 continuous months of living in a gender role that is congruent with their gender identity

Although not an explicit criterion, it is recommended that these individuals also have regular visits with a mental health or other medical professional.

- **If benefit coverage for gender dysphoria treatment is available,** all other surgical procedures are considered ***cosmetic, not eligible for coverage*** and ***not medically necessary***. See page 10 for list of procedures.

- **If benefit coverage for gender dysphoria treatment is not available,** surgical procedures for gender dysphoria are considered ***a benefit plan exclusion*** and ***not eligible for coverage***.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Female-to-Male: (cont.)

Other Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** preoperative permanent removal of genital hair with electrolysis prior to a metoidioplasty, phalloplasty, scrotoplasty and urethroplasty is considered ***eligible for coverage***.
- **If benefit coverage for gender dysphoria treatment is available,** postoperative permanent removal of genital hair with electrolysis following a metoidioplasty, phalloplasty, scrotoplasty and urethroplasty is considered ***eligible for coverage*** with documentation that postoperative genital hair is causing functional limitation or dysfunction.
- **If benefit coverage for gender dysphoria treatment is available,** permanent removal of genital hair with electrolysis for all other indications not previously listed or if above criteria not met is considered ***cosmetic, not eligible for coverage*** and ***not medically necessary***. See page 10 for list of other hair procedures.
- **If benefit coverage for gender dysphoria treatment is not available,** permanent removal of genital hair with electrolysis is considered ***a benefit plan exclusion*** and ***not eligible for coverage***.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Male-to-Female:

Surgical Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** the following surgical procedures are considered ***eligible for coverage***:

1. Initial breast augmentation (implants/lipofilling) with documentation of **ALL** of the following:

   - One referral from qualified mental health professional
   - Persistent, well-documented gender dysphoria
   - Capacity to make a fully informed decision and to give consent for treatment
   - Age of majority in a given country (if younger, follow the SOC for children and adolescents)
   - If significant medical or mental health concerns are present, they must be reasonably well controlled

Although not an explicit criterion, feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery is recommended. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

2. Orchiectomy and penectomy with documentation of **ALL** of the following:

   - Two referrals from qualified mental health professionals
   - Persistent, well documented gender dysphoria
   - Capacity to make a fully informed decision and to give consent for treatment
   - Age of majority in a given country
   - If significant medical or mental health concerns are present, they must be well controlled
   - 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless hormones are not clinically indicated for the individual)

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, prior to irreversible surgical intervention.

These criteria do not apply to individuals having these surgical procedures for medical indications other than gender dysphoria.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Male-to-Female: (cont.)

Surgical Procedures for Gender Dysphoria: (cont.)

- **If benefit coverage for gender dysphoria treatment is available,** the following surgical procedures are considered ***eligible for coverage***: (cont.)

  3. Clitoroplasty, urethroplasty, vaginoplasty and vulvoplasty with documentation of **ALL** of the following:

     - Two referrals from qualified mental health professionals
     - Persistent, well documented gender dysphoria
     - Capacity to make a fully informed decision and to consent for treatment
     - Age of majority in a given country
     - If significant medical or mental health concerns are present, they must be well controlled
     - 12 continuous months of hormone therapy as appropriate to the individual's gender goals (unless hormones are not clinically indicated for the individual)
     - 12 continuous months of living in a gender role that is congruent with their gender identity

Although not an explicit criterion, it is recommended that these individuals also have regular visits with a mental health or other medical professional.

- **If benefit coverage for gender dysphoria treatment is available,** all other surgical procedures are considered ***cosmetic, not eligible for coverage*** and ***not medically necessary***. See page 10 for list of procedures.

- **If benefit coverage for gender dysphoria treatment is not available,** surgical procedures for gender dysphoria are considered ***a benefit plan exclusion*** and ***not eligible for coverage***.

Other Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** preoperative permanent removal of genital hair with electrolysis prior to a clitoroplasty, penectomy, urethroplasty, vaginoplasty and vulvoplasty is considered ***eligible for coverage***.

- **If benefit coverage for gender dysphoria treatment is available,** postoperative permanent removal of genital hair with electrolysis following a clitoroplasty, penectomy, urethroplasty, vaginoplasty and is considered ***eligible for coverage*** with documentation that postoperative genital hair is causing functional limitation or dysfunction.

- **If benefit coverage for gender dysphoria treatment is not available,** permanent removal of genital hair with electrolysis is considered ***a benefit plan exclusion*** and ***not eligible for coverage***.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Cosmetic Surgical Procedures for Gender Dysphoria:

- **If benefit coverage for gender dysphoria treatment is available,** the following procedures are considered ***cosmetic, not eligible for coverage*** and ***not medically necessary***.

  These procedures include, *but are not limited to:*

1. Abdominoplasty
2. Blepharoplasty
3. Brow lift
4. Calf implants
5. Cheek/malar implants/enhancement
6. Chest contouring (lipofilling, liposuction)
7. Chin/nose augmentation (implants) and contouring
8. Collagen injections
9. Face lift
10. Forehead lengthening, augmentation and reduction/contouring
11. Facial feminization/masculinization surgery
12. Gluteal augmentation (implants/lipofilling)
13. Hair transplantation
14. Hairline advancement
15. Jaw augmentation and shortening/sculpturing/facial bone reduction
16. Lip reduction and augmentation/enhancement
17. Lipofilling
18. Liposuction
19. Mastopexy
20. Neck tightening
21. Nipple/areola reconstruction
22. Pectoral implants
23. Permanent removal of genital hair with electrolysis for all other indications not previously listed or if above criteria not met
24. Removal of non-genital hair (electrolysis, laser)
25. Removal of redundant skin
26. Repeat female-to-male genital surgical procedures
27. Repeat male-to-female breast augmentation (implants/lipofilling) or revisions to initial breast augmentation (implants/lipofilling)
28. Replacement of tissue expander with permanent prosthesis testicular insertion
29. Rhinoplasty
30. Skin resurfacing (e.g., dermabrasion, chemical peels)
31. Thyroid cartilage augmentation/enhancement and reduction/trachea shave
32. Voice modification surgery/laryngoplasty
33. Voice therapy/voice lessons

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Criteria: (cont.)

Fertility/Infertility Services for Gender Dysphoria:

COVERAGE FOR FERTILITY/INFERTILITY SERVICES FOR GENDER DYSPHORIC MEMBERS IS DEPENDENT UPON BENEFIT PLAN LANGUAGE. REFER TO MEMBER'S SPECIFIC BENEFIT PLAN BOOKLET TO VERIFY BENEFITS UNDER SERVICES TO DIAGNOSE INFERTILITY AND/OR FERTILITY AND INFERTILITY SERVICES.

If benefit coverage for fertility/infertility services is available, requests for fertility/infertility services will be reviewed by the medical director(s) and/or clinical advisor(s).

Resources:

Literature reviewed 09/04/18. We do not include marketing materials, poster boards and non-published literature in our review.

1. Blue Cross Blue Shield of Arizona Benefit Plan Booklet.

2. The Endocrine Society. Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism.* 07/02/2013.

3. The World Professional Association for Transgender Health (WPATH). Standards of Care for the Health of Transsexual, Transgender and Gender-Nonconforming People. 2012, Version 7.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Non-Discrimination Statement:

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Multi-Language Interpreter Services:

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídílkidgo éí doodago Háida bíjá anilyeedigíí t'áadoo le'é yina'ídilkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowolgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 877-475-4799.

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TREATMENTS FOR GENDER DYSPHORIA (cont.)

Multi-Language Interpreter Services: (cont.)

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید، سوال در مورد Blue Cross Blue Shield of Arizona داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
تماس حاصل نمایید.].

Assyrian:
Blue Cross Blue Shield of Arizona
877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกำลังช่วยเหลืออยู่มีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษา ของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

EXHIBIT E

Medical Coverage Policy

Effective Date **4/15/2019**
Next Review Date **3/15/2020**
Coverage Policy Number **0266**

Treatment of Gender Dysphoria

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INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses treatment of gender dysphoria. Gender dysphoria is defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and the person's assigned sex at birth (World Professional Association for Transgender Health, [WPATH], 2012).

Coverage Policy

Coverage for treatment of gender dysphoria varies across plans. Refer to the customer's benefit plan document for coverage details. Coverage for treatment of gender dysphoria, including gender reassignment surgery and related may be governed by state and/or federal mandates.

Unless otherwise specified in a benefit plan, the following conditions of coverage apply for treatment of gender dysphoria and/or gender reassignment surgery and related procedures, including all applicable benefit limitations, precertification, or other medical necessity criteria.

SERVICES MEDICALLY NECESSARY

Medically necessary treatment for an individual with gender dysphoria may include ANY of the following services, when services are available in the benefit plan:

- Behavioral health services, including but not limited to, counseling for gender dysphoria and related psychiatric conditions (e.g., anxiety, depression)
- Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues, estrogens, and progestins.
- Laboratory testing to monitor prescribed hormonal therapy
- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individuals biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition)
- Gender reassignment and related surgery (see below).

Gender Reassignment Surgery

Gender reassignment surgery (see Table 1) is considered medically necessary treatment of gender dysphoria when the individual is age 18 years or older and when the following criteria are met:

- **For initial mastectomy:** one letter of support from a qualified mental health professional

  NOTE: The Women's Health and Cancer Rights Act (WHCRA), 29 U.S. Code § 1185b requires coverage of certain post-mastectomy services related to breast reconstruction and treatment of physical complications from mastectomy including nipple-areola reconstruction.

- **For hysterectomy, salpingo-oophorectomy, orchiectomy:**
  - documentation of at least 12 months of continuous hormonal sex reassignment therapy AND
  - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required.

- **For reconstructive genital surgery:**
  - documentation of at least 12 months of continuous hormonal sex reassignment therapy AND
  - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required AND
  - documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity.

Table 1: Gender Reassignment Surgery

Procedure	CPT / HCPCS codes (This list may not be all inclusive)
Initial mastectomy*, nipple-areola reconstruction (related to mastectomy or post mastectomy reconstruction)	19303, 19304, 19350
Hysterectomy and salpingo-oophorectomy	58150, 58260 58262 58291, 58552, 58554,

	58571, 58573, 58661
Female to male reconstructive genital surgery which may include any of the following: Vaginectomy**/colpectomy Vulvectomy Metoidioplasty Phalloplasty Electrolysis of donor site tissue to be used for phalloplasty Penile prosthesis (noninflatable / inflatable), including surgical correction of malfunctioning pump, cylinders, or reservoir Urethroplasty /urethromeatoplasty	55980 57110 56625 58999 58999 17380 54400, 54401, 54405, C1813, C2622 53430, 53450
Orchiectomy	54520, 54690
Male to female reconstructive genital surgery, which may include any of the following: Vaginoplasty**, (e.g, construction of vagina with/without graft, colovaginoplasty) Electrolysis of donor site tissue to be used to line the vaginal canal for vaginoplasty Penectomy Vulvoplasty, (e.g., labiaplasty, clitoroplasty, penile skin inversion) Repair of introitus Coloproctostomy	55970 57291, 57292, 57335 17380 54125 56620, 56805 56800 44145, 55899

***Note: Please reference the Cigna Medical Coverage Policy 0152 Reduction Mammoplasty for conditions of coverage related to breast reduction.**

****Note: For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months continuous hormonal sex reassignment therapy is required. An additional 12 months of hormone therapy is not required for vaginectomy or vaginoplasty procedures.**

NOT MEDICALLY NECESSARY SERVICES
Gender reassignment surgery is considered not medically necessary when the applicable medical necessity criteria for the procedure(s) has not been met.

Each of the following is excluded under many benefit plans and/or considered not medically necessary as part of gender reassignment for preservation of fertility (see Table 2):

Table: 2 Excluded and/or Not Medically Necessary- Fertility Preservation

Procedure	CPT/HCPCS Code
Cryopreservation of embryo, sperm, oocytes	89258, 89259, 89337
Procurement of embryo, sperm, oocytes	S4030, S4031
Storage of embryo, sperm, oocytes	89342, 89343, 89346, S4027, S4040

EXPERIMENTAL /INVESTIGATIONAL/UNPROVEN SERVICES
Each of the following is considered experimental, investigational or unproven as part of gender reassignment for the preservation of fertility (see Table 3):

Table: 3 Experimental, Investigational or Unproven - Fertility Preservation

Procedure	CPT/HCPCS Code
Cryopreservation of immature oocytes	0357T
Cryopreservation of reproductive tissue (i.e., ovaries, testicular tissue)	89335, 0058T
Storage of reproductive tissue (i.e., ovaries, testicular tissue)	89344
Thawing of reproductive tissue (i.e., ovaries, testicular tissue)	89354

COSMETIC SERVICES

Each of the following services (see Table 4) is considered cosmetic and/or not medically necessary for the purpose of improving or altering appearance or self-esteem related to one's appearance, including gender specific appearance for an individual with gender dysphoria:

Table 4: Cosmetic and/or Not Medically Necessary (Unless coverage is specifically listed as available in the applicable benefit plan document)

Facial Feminization/Masculinization Procedures	CPT/HCPCS Code
Blepharoplasty	15820, 15821, 15822, 15823
Cheek/malar implants	17999
Chin/nose implants	21210, 21270, 30400, 30410, 30420, 30430 30435, 30450
Collagen injections	11950, 11951, 11952, 11954
Face/forehead lift	15824, 15825, 15826, 15828, 15829, 21137
Facial bone reduction (osteoplasty)	21209
Hair removal/hair transplantation	15775, 15776, 17380
Jaw reduction	21120, 21121, 21122, 21223, 21125, 21127
Laryngoplasty	31599
Rhinoplasty	21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450
Skin resurfacing (e.g., dermabrasion, chemical peels)	15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793
Thyroid reduction chondroplasty	31750
Neck tightening	15825

Chest Reconstruction Procedures	CPT/HCPCS Code
Breast augmentation with implants	19324, 19325, 19340, 19342, C1789
Mastopexy	19316
Nipple/areola reconstruction (unrelated to mastectomy or post mastectomy reconstruction)	19350
Pectoral Implants	L8600, 17999

Voice Modification Therapy/Procedures	CPT/HCPCS Code
Voice modification surgery	31599, 31899
Voice therapy/voice lessons	92507

Other Miscellaneous Procedures	CPT/HCPCS Code
Abdominoplasty	15847

Calf implants	17999
Electrolysis, other than when performed pre-vaginoplasty as outlined above	17380
Insertion of testicular prosthesis	54660
Removal of redundant skin	15830, 15832, 15833, 15834, 15835, 15836 15837, 15838, 15839
Replacement of tissue expander with permanent prosthesis testicular insertion	11970
Scrotoplasty	55175, 55180
Suction assisted lipoplasty, lipofilling, and/or liposuction	15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879
Testicular expanders, including replacement with prosthesis, testicular prosthesis	11960, 11970, 11971, 54660

General Background

The causes of gender dysphoria and the developmental factors associated with them are not well-understood. Treatment of individuals with gender dysphoria varies, with some treatments involving a change in gender expression or body modifications. The term “transsexual” refers to an individual whose gender identity is not congruent with their genetic and/or assigned sex and usually seeks hormone replacement therapy (HRT) and possibly gender-affirmation surgery to feminize or masculinize the body and who may live full-time in the crossgender role. Transsexualism is a form of gender dysphoria. Other differential diagnoses include, but are not limited to, partial or temporary disorders as seen in adolescent crisis, transvestitism, refusal to accept a homosexual orientation, psychotic misjudgments of gender identity and severe personality disorders (Becker, et al., 1998). Individuals that are transsexual, transgender, or gender nonconforming (i.e., gender identity differs from the cultural norm) may experience gender dysphoria.

Treatment of gender dysphoria is unique to each individual and may or may not involve body modifications. Some individuals require only psychotherapy, some require a change in gender roles/expression, and others require hormone therapy and/or surgery to facilitate a gender transition.

Behavioral Health Services

Licensing requirements and scope of practice vary by state for healthcare professionals. WPATH has defined recommended minimum credentials for a mental health professional to be qualified to evaluate or treat adult individuals with gender dysphoria. In addition to general licensing requirements, WPATH includes a minimum of a Master’s or more advanced degree from an accredited institution, an ability to recognize and diagnose coexisting mental health concerns, and an ability to distinguish such conditions from gender dysphoria. Mental health professionals play a strong role in working with individuals with gender dysphoria as they need to diagnose the gender disorder and any co-morbid psychiatric conditions accurately, counsel the individual regarding treatment options, and provide psychotherapy (as needed) and assess eligibility and readiness for hormone and surgical therapy. For children and adolescents, the mental health professional should also be trained in child and adolescent developmental psychopathology.

Once the individual is evaluated, the mental health professional provides documentation and formal recommendations to medical and surgical specialists. Documentation for hormonal and/or surgery should be comprehensive and include the extent to which eligibility criteria have been met (i.e., confirmed gender dysphoria, capacity to make a fully informed decision, age ≥ 18 years or age of majority, and other significant medical or behavioral health concerns are well-controlled), in addition to the following:

- individual’s general identifying characteristics
- the initial and evolving gender, sexual and psychiatric diagnoses
- details regarding the type and duration of psychotherapy or evaluation the individual received
- the mental health professional’s rationale for hormone therapy or surgery
- the degree to which the individual has followed the standards of care and likelihood of continued compliance

- whether or not the mental health professional is a part of a gender team

For breast surgery WPATH Standards of Care Version 7 require one referral from a qualified mental health professional, as defined above. For genital surgery WPATH requires two referrals from qualified mental health professionals indicating criteria for surgery has been met. In contrast, the Endocrine Society Clinical Practice Guidelines (Hembree, et al., 2009) recommend both an endocrinologist responsible for endocrine transition therapy and a mental health professional certify the individual is eligible and meets WPATH criteria for gender reassignment surgery.

Psychiatric care may need to continue for several years after gender reassignment surgery, as major psychological adjustments may continue to be necessary. Other providers of care may include a family physician or internist, endocrinologist, urologist, plastic surgeon, general surgeon and gynecologist. The overall success of the surgery is highly dependent on psychological adjustment and continued support.

After diagnosis, the therapeutic approach is individualized but generally includes three elements: sex hormone therapy of the identified gender, real life experience in the desired role, and surgery to change the genitalia and other sex characteristics.

Hormonal Therapy
For both adults and adolescents, hormonal treatment for gender dysphoria must be administered and monitored by a qualified healthcare practitioner as therapy requires ongoing medical management, including physical examination and laboratory evaluation studies to manage dosage, side effects, etc. Lifelong maintenance is usually required.

Adults: Prior to and following gender reassignment surgery, individuals undergo hormone replacement therapy, unless medically contraindicated. Biological males are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. Biological females are treated with androgens such as testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. In both sexes hormone replacement therapy (HRT) may be effective in reducing the adverse psychologic impact of gender dysphoria. Hormone therapy is usually initiated upon referral from a qualified mental health professional or a health professional competent in behavioral health and gender dysphoria treatment specifically. Twelve months of continuous hormone therapy (gender appropriate) is required prior to hysterectomy and salpingo-oophorectomy and orchiectomy.

Adolescents: Puberty-suppressing hormones (e.g., GnRH analogues) for adolescents may be provided to individuals who have reached at least Tanner stage 2 of sexual development. The Endocrine Society supports puberty suppression and has developed criteria for a subset of individuals who fulfill and meet eligibility readiness for gender reassignment (Hembree, et al., 2009). WPATH clinical recommendations also support puberty suppression (WPATH, 2012) for a similar subset of individuals. Consistent with adult hormone therapy, treatment of adolescents involves a multidisciplinary team, however when treating an adolescent a pediatric endocrinologist should be included as a part of the team. Pre-pubertal hormone suppression differs from hormone therapy used in adults and may not be without consequence; some pharmaceutical agents may cause negative physical side effects (e.g., height, bone growth).

Gender Reassignment Surgery
The term "gender reassignment surgery," also known as sexual reassignment surgery, gender confirming surgery or gender affirmation surgery, may be part of a treatment plan for gender dysphoria. The terms may be used to refer to either the reconstruction of male or female genitalia specifically, or the reshaping by any surgical procedure of a male body into a body with female appearance, or vice versa.

Gender identity disorder does not persist into adolescence in most children (Hembree, et al., 2009). Evidence suggests that 75-80% of prepubertal children do not turn out to be transsexual in adolescence (Hembree, et al., 2009). According to WPATH (2007) persistence of gender dysphoria from adolescence into adulthood is much higher. Performing gender reassignment surgery prior to age 18, or the legal age to give consent, is not recommended by professional societies (American College of Obstetricians and Gynecology [ACOG], 2017;

WPATH, 2012; American Psychiatric Association (APA), 2012, Endocrine Society, 2009). Gender reassignment surgery is intended to be a permanent change (non-reversible), establishing congruency between an individual's gender identity and physical appearance. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrine and urological examination, and a clinical psychiatric/psychological examination. Individuals who choose to undergo gender reassignment surgery must be fully informed regarding treatment options with confirmation from the mental health professional that the individual is considered a candidate for surgical treatment.

Twelve months of continuous hormone therapy is required prior to irreversible genital surgery. In addition, prior to surgery the individual identified with gender dysphoria must undergo a "real life experience," in which he/she adopts the new or evolving gender role and lives in that role for at least 12 continuous months as part of the transition pathway. This process assists in confirming the person's desire for gender role change, ability to function in this role long-term, as well as the adequacy of his/her support system. During this time, a person would be expected to maintain their baseline functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role.

Other Associated Surgical Procedures

Services Otherwise Medically Necessary: Age appropriate gender-specific services that would otherwise be considered medically necessary remain medically necessary services for transgender individuals, as appropriate to their biological anatomy. Examples include (but are not limited to):

- for female to male transgender individuals who have not undergone a mastectomy, breast cancer and cervical cancer screening
- for male to female transgender individuals who have retained their prostate cancer screening or treatment of a prostate condition.

Reversal of Gender Reassignment: Gender reassignment surgery is considered an irreversible intervention (WPATH, 2012). Although infrequent, surgery to reverse a partially or fully completed gender reassignment (reversal of surgery to revise secondary sex characteristics), may be necessary as a result of a complication (i.e., infection) or other medical condition necessitating surgical intervention.

Fertility Preservation: Both hormone therapy and gender reassignment surgery limits fertility, and individuals should be informed of sperm preservation options and other cryopreservation services prior to starting hormone therapy. Reproductive options should also be discussed prior to surgery for individuals who are of child-bearing age. However, procedures aimed at preservation of fertility (e.g., procurement, cryopreservation, and storage of sperm, oocytes and/or embryos) performed prior to gender reassignment surgery are considered not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations, and applicable Cigna Medical Coverage Policy for conditions of coverage.

Cosmetic Procedures: Various other surgical procedures may be performed as part of gender reassignment surgery. Although WPATH does not define medical necessity criteria for masculinization and feminization procedures, referral by a qualified mental health professional is recommended. When performed as part of gender reassignment surgery such procedures, aimed primarily at improving personal appearance (i.e., masculinization, feminization), are performed to assist with improving culturally appropriate male or female appearance characteristics and are therefore considered cosmetic and are not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations, and applicable Cigna Medical Coverage Policy for conditions of coverage.

Professional Society/Organization

American College of Obstetricians and Gynecologists (ACOG): ACOG published a Committee Opinion in 2017 for the care of transgender adolescents. Within this document regarding surgical management ACOG notes transgender male patients may undergo phalloplasty when one reaches the age of majority, and a transgender female patient may undergo vaginoplasty when one reaches the age of majority. In addition the authors acknowledge the Endocrine Society guidelines (Hembree, et al., 2009) which state that an individual is at least age 18 years for genital reconstructive surgery (ACOG, 2017).

American Psychiatric Association (APA): In 2012 the APA published a task force report on treatment of gender identity disorder. Within this document, regarding adolescents specifically, the authors state the evidence is inadequate to develop a guideline regarding the timing of sex reassignment surgery. However the task force acknowledges the Endocrine Society guidelines (Hembree, et al., 2009) and that given the irreversible nature of surgery, for adolescents most clinicians advise waiting until the individual has attained the age of legal consent and a degree of independence (APA, 2012).

WPATH Standards of Care: The World Professional Association for Transgender Health (WPATH) promotes standards of health care for individuals through the articulation of "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" (WPATH, 2012, Version 7). WPATH standards of care are based on scientific evidence and expert consensus and are commonly utilized as clinical recommendations for individuals seeking treatment of gender disorders.

Endocrine Society: In 2009 the Endocrine Society published a clinical practice guideline for endocrine treatment of transsexual persons (Hembree, et al., 2009). As part of this guideline, the endocrine society recommends that transsexual persons consider genital sex reassignment surgery only after both the physician responsible for endocrine transition therapy and the mental health professional find surgery advisable; that surgery be recommended only after completion of at least one year of consistent and compliant hormone treatment; and that the physician responsible for endocrine treatment medically clear the individual for sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery.

Centers for Medicare & Medicaid Services (CMS

- National Coverage Determination (NCD): No NCD found.
- Local Coverage Determination (LCD): No LCD found.

Use Outside of the US: Several other countries including the United Kingdom offer treatment options for individuals with gender dysphoria. Treatments are similar to those offered in the United States.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Intersex Surgery: Male to Female

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
55970†	Intersex surgery; male to female
	†**Includes only the following procedures:**
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchiectomy
55899††	Unlisted procedure, male genital system
56620	Vulvectomy simple; partial
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state

††**Note: Considered medically necessary when used to report Coloproctostomy.**

Intersex Surgery: Female to Male

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
55980†	Intersex surgery, female to male
	†**Includes only the following procedures:**
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19350††	Nipple/areola reconstruction
53430	Urethroplasty, reconstruction of female urethra
53450	Urethromeatoplasty, with mucosal advancement
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
56625	Vulvectomy simple; complete
57110	Vaginectomy, complete removal of vaginal wall
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58999†††	Unlisted procedure, female genital system (nonobstetrical)

††**Note: Considered medically necessary when performed as part of a mastectomy or breast reconstruction procedure following a mastectomy.**

†††**Note: Considered medically necessary when used to report metoidioplasty with phalloplasty.**

HCPCS Codes	Description
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable

ICD-10-CM Diagnosis Codes	Description
F64.0	Trans-sexualism

F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Generally Excluded/Not Medically Necessary:

CPT®* Codes	Description
89258	Cryopreservation; embryo(s)
89259	Cryopreservation; sperm
89337	Cryopreservation, mature oocyte(s)
89342	Storage (per year); embryo(s)
89343	Storage (per year); sperm/semen
89346	Storage (per year); oocyte(s)

HCPCS Codes	Description
S4027	Storage of previously frozen embryos
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit
S4040	Monitoring and storage of cryopreserved embryos, per 30 days

Considered Experimental/Investigational/Unproven:

CPT®* Codes	Description
89335	Cryopreservation, reproductive tissue, testicular
89344	Storage (per year); reproductive tissue, testicular/ovarian
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian
0058T	Cryopreservation; reproductive tissue, ovarian
0357T	Cryopreservation; immature oocyte(s)

Considered Cosmetic and/or not medically necessary when performed as a component of gender reassignment, even when coverage for gender reassignment surgery exists unless subject to a coverage mandate:

CPT®* Codes	Description
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary

	procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy, forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999†	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316	Mastopexy
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350††	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599†††	Unlisted procedure, larynx
31750	Tracheoplasty; cervical
31899††††	Unlisted procedure, trachea, bronchi
40799†††††	Unlisted procedure, lips
54660	Insertion of testicular prosthesis (separate procedure)
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

HCPCS Codes	Description
C1789	Prosthesis, breast (implantable)
L8600	Implantable breast prosthesis, silicone or equal

†**Note: Cosmetic and/or not medically necessary when used to report calf, cheek, malar or pectoral implants or fat transfers performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.**

††**Note: Cosmetic and/or not medically necessary when not performed as part of a mastectomy or breast reconstructive procedure.**

†††**Note: Cosmetic and/or not medically necessary when used to report laryngoplasty performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.**

††††**Note: Cosmetic and/or not medically necessary when used to report voice modification surgery performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.**

†††††**Note: Cosmetic and/or not medically necessary when used to report lip reduction/enhancement performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.**

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EXHIBIT F

UnitedHealthcare Community Plan

UnitedHealthcare® Community Plan
Medical Policy

GENDER DYSPHORIA TREATMENT

Policy Number: CS145.F **Effective Date**: January 1, 2020

Instructions for Use

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- Speech Language Pathology Services

Commercial Policy

- Gender Dysphoria Treatment

APPLICATION

This policy does not apply to the state of Tennessee.

COVERAGE RATIONALE

See Benefit Considerations

Note: This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development.

Gender reassignment surgery may be indicated for individuals who provide the following documentation:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria is needed for breast surgery. The assessment must document that an individual meets **all** of the following criteria:
  - Persistent, well-documented Gender Dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age (age of majority)
  - If significant medical or mental health concerns are present, they must be reasonably well controlled
- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the individual, are required for genital surgery. The assessment must document that an individual meets **all** of the following criteria:
  - Persistent, well-documented Gender Dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age (age of majority)
  - If significant medical or mental health concerns are present, they must be reasonably well controlled
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated)
- Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating Gender Dysphoria.

*See the Optum Coverage Determination Guideline titled *Gender Dysphoria* for provider qualification criteria (to access this guideline, go to: Optum Provider Express > Clinical Resources > Guidelines/Policies/Manuals > Coverage Determination Guidelines).

When the above criteria are met, the following gender reassignment surgical procedures are medically necessary and covered as a proven benefit:

- **Male-to-Female (MtF)**:
  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)
  - Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of gender dysphoria
- **Female-to-Male (FtM)**:
  - Bilateral mastectomy or breast reduction*
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prostheses
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)
  - Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of gender dysphoria

*Bilateral mastectomy or breast reduction may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the individual does not need to complete hormone therapy prior to procedure.

Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary when performed as part of gender reassignment:

- Abdominoplasty (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)
- Blepharoplasty (also see the Coverage Determination Guideline titled Blepharoplasty, Blepharoptosis and Brow Ptosis Repair)
- Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)
- Breast enlargement, including augmentation mammaplasty and breast implants
- Brow lift
- Calf implants
- Cheek, chin and nose implants
- Face/forehead lift and/or neck tightening
- Facial bone remodeling for facial feminization
- Hair transplantation
- Injection of fillers or neurotoxins (also see the Medical Benefit Drug Policy titled Botulinum Toxins A and B)
- Laser or electrolysis hair removal not related to genital reconstruction
- Lip augmentation
- Lip reduction
- Liposuction (suction-assisted lipectomy) (also see the Coverage Determination Guideline titled Panniculectomy and Body Contouring Procedures)
- Mastopexy
- Pectoral implants for chest masculinization
- Rhinoplasty (also see the Coverage Determination Guideline titled Rhinoplasty and Other Nasal Surgeries)
- Skin resurfacing (e.g., dermabrasion, chemical peels, laser)
- Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
- Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords)
- Voice lessons and voice therapy

DEFINITIONS

Gender Dysphoria in Adolescents and Adults: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):

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

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

Gender Dysphoria in Children: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least six** of the following (**one of which must be criterion A1**):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
   3. A strong preference for cross-gender roles in make-believe play or fantasy play
   4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
   5. A strong preference for playmates of the other gender
   6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities
   7. A strong dislike of one's sexual anatomy
   8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender

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

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity

CPT Code	Description
15750	Flap; neurovascular pedicle
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area

CPT Code	Description
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
21899	Unlisted procedure, neck or thorax
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair

CPT Code	Description
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

CPT Code	Description
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral;
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

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ICD-10 Diagnosis Code	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

DESCRIPTION OF SERVICES

Gender Dysphoria is a condition in which there is a marked incongruence between an individual's experienced/expressed gender and assigned gender (DSM-5). Treatment options include behavioral therapy, psychotherapy, hormone therapy and surgery for gender reassignment, which can involve genital reconstruction surgery and breast/chest surgery. For the FtM patient, surgical procedures may include mastectomy, hysterectomy, salpingo-oophorectomy, vaginectomy, vulvectomy, scrotoplasty, urethroplasty, placement of testicular and/or penile prostheses and phalloplasty or metoidioplasty (alternative to phalloplasty). For the MtF patient, surgical procedures may include penectomy, vaginoplasty, clitoroplasty, labiaplasty, orchiectomy and urethroplasty.

Other terms used to describe surgery for Gender Dysphoria include sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex reassignment.

BENEFIT CONSIDERATIONS

Coverage Information

Unless otherwise specified, if a plan covers treatment for gender dysphoria, coverage includes psychotherapy, cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. This benefit also includes certain surgical treatments listed in the Coverage Rationale section. See the Medical Benefit Drug Policy titled Gonadotropin Releasing Hormone Analogs.

Limitations and Exclusions

Certain treatments and services are not covered. Examples include, but are not limited to:

- Treatment received outside of the United States
- Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm and host uterus (please check the federal, state or contractual requirements for benefit coverage)
- Transportation, meals, lodging or similar expenses
- Cosmetic procedures (see Coverage Determination Guideline titled Cosmetic and Reconstructive Procedures and the Coverage Rationale section)
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics

Benefits are limited to one sex transformation reassignment per lifetime which may include several staged procedures.

Coverage does not apply to members who do not meet the indications listed in the Coverage Rationale section.

CLINICAL EVIDENCE

An ECRI special report systematically reviewed the clinical literature to assess the efficacy of treatments for gender dysphoria. The authors identified limited evidence from mostly low-quality retrospective studies. Evidence on gender reassignment surgery was mostly limited to evaluations of MtF individuals undergoing vaginoplasty, facial feminization surgery and breast augmentation. Outcomes included mortality, patient satisfaction, physical well-being, psychological-related outcomes, quality of life, sexual-related outcomes, suicide and adverse events. Concluding remarks included the need for standardized protocols and prospective studies using standardized measures for correct interpretation and comparability of data (ECRI, 2016).

A Hayes report concluded that, overall, the quality of the evidence on gender reassignment surgery for gender dysphoria was very low (Hayes, 2014a; updated 2018). The evidence suggests positive benefits, but because of serious limitations, permits only weak conclusions. Limitations include small sample sizes, retrospective data, lack of randomization and control and a lack of objective and validated outcome measures.

- Patients who underwent chest/breast or genital surgery were generally pleased with the aesthetic results.
- Following gender reassignment surgery, patients reported decreased gender dysphoria, depression and anxiety and increased quality of life.
- The majority of gender reassignment surgery patients were sexually active, but the ability to orgasm varied across studies.
- Complications of surgery following gender reassignment surgery were common and could be serious.
- Rates of regret of surgery and suicide were very low following gender reassignment surgery.
- Data were too sparse to draw conclusions regarding whether gender reassignment surgery conferred additional benefits to hormone therapy alone.
- Data were too sparse to draw conclusions regarding whether outcomes vary according to which surgeries were performed.

A separate Hayes report concluded that, overall, the quality of the evidence on ancillary procedures for the treatment of gender dysphoria was very low (Hayes, 2014b; updated 2018). There is some evidence that transgender patients are satisfied with the results of rhinoplasty and facial feminization surgery, but patient satisfaction with vocal cord surgery and voice training was mixed. The evidence has serious limitations, and the effect of these procedures on overall individual well-being is unknown.

- Patients who had rhinoplasty or facial feminization surgery were generally pleased with the results.
- Vocal cord procedures and voice training had variable outcomes. Although the fundamental frequency was reduced by all treatment methods, patient satisfaction with the outcome was mixed.
- Most of the studies did not report complications; however, there was a low rate of bone nonunion following facial surgery, and moderate rates of dysphagia or throat pain following cricothyroid approximation.

Mahfouda et al. (2019) conducted a systematic review of the the available published evidence on gender-affirming cross-sex hormone (CSH) and surgical interventions in transgender children and adolescents, amalgamating findings on mental health outcomes, cognitive and physical effects, side-effects, and safety variables. The small amount of available data suggest that when clearly indicated in accordance with international guidelines, gender-affirming CSHs and chest wall masculinisation in transgender males are associated with improvements in mental health and quality of life. Evidence regarding surgical vaginoplasty in transgender females younger than age 18 years remains extremely scarce and conclusions cannot yet be drawn regarding its risks and benefits in this age group. Further research on an international scale is urgently warranted to clarify long-term outcomes on psychological functioning and safety.

Dreher et al. (2018) conducted a systematic review and meta-analysis to evaluate the epidemiology, presentation, management, and outcomes of neovaginal complications in the MtF transgender reassignment surgery patients. Selected studies reported on 1,684 patients with an overall complication rate of 32.5% and a reoperation rate of 21.7% for non-esthetic reasons. The most common complication was stenosis of the neo-meatus (14.4%). Wound infection was associated with an increased risk of all tissue-healing complications. Use of sacrospinous ligament fixation (SSL) was associated with a significantly decreased risk of prolapse of the neovagina. The authors concluded that gender-affirmation surgery is important in the treatment of gender dysphoric patients, but there is a high complication rate in the reported literature. Variability in technique and complication reporting standards makes it difficult to assess the accurately the current state of MtF gender reassignment surgery. Further research and implementation of standards is necessary to improve patient outcomes.

Manrique et al (2018) conducted a systematic review of retrospective studies on the outcomes of MtF vaginoplasty to minimize surgical complications and improve patient outcomes for transgender patients. Forty-six studies met the authors eligibility criteria. A total of 3716 cases were analyzed. The results showed the overall incidence of complications as follows: 2% fistula, 14% stenosis and strictures, 1% tissue necrosis, and 4% prolapse. Patient-reported outcomes included a satisfaction rate of 93% with overall results, 87% with functional outcomes, and 90% with esthetic outcomes. Ability to have orgasm was reported in 70% of patients. The regret rate was 1%. The authors concluded that multiple surgical techniques have demonstrated safe and reliable means of MtF vaginoplasty with low overall complication rates and with a significant improvement in the patient's quality of life. Studies using different techniques in a similar population and standardized patient-reported outcomes are required to further analyze outcomes among the different procedures and to establish best-practice guidelines.

Van Damme et al. (2017) conducted a systematic review of the effectiveness of pitch-raising surgery performed in MtF transsexuals. Twenty studies were included: eight using cricothyroid approximation, six using anterior glottal web formation and six using other surgery types or a combination of surgical techniques. A substantial rise in postoperative frequency was identified. The majority of patients seemed satisfied with the outcome. However, none of the studies used a control group and randomization process. Further investigation regarding long-term results using a stronger study design is necessary.

Morrison et al. (2016) conducted a systematic review of the facial feminization surgery literature. Fifteen studies were included, all of which were either retrospective or case series/reports. The studies covered a variety of facial feminization procedures. A total of 1121 patients underwent facial feminization surgery, with seven complications reported, although many studies did not explicitly comment on complications. Satisfaction was high, although most studies did not use validated or quantified approaches to address satisfaction. The authors noted that further studies are needed to better compare different techniques to more robustly establish best practices. Prospective studies and patient-reported outcomes are needed to establish quality of life outcomes for patients.

Frey et al. (2016) conducted a systematic review of metoidioplasty and radial forearm flap phalloplasty (RFFP) in FtM transgender genital reconstruction. Eighteen studies were included: 7 for metoidioplasty and 11 for RFFP. The quality of evidence was low to very low for all included studies. In studies examining metoidioplasty, the average study size and length of follow-up were 54 patients and 4.6 years, respectively (1 study did not report [NR]). Eighty-eight percent underwent a single-stage reconstruction, 87% reported an aesthetic neophallus (3 NR) and 100% reported erogenous sensation (2 NR). Fifty-one percent of patients reported successful intercourse (3 NR) and 89% of patients achieved standing micturition (3 NR). In studies examining RFFP, the average study size and follow-up were 60.4 patients and 6.23 years, respectively (6 NR). No patients underwent single-stage reconstructions (8 NR). Seventy percent of patients reported a satisfactorily aesthetic neophallus (4 NR) and 69% reported erogenous sensation (6 NR). Forty-three percent reported successful penetration of partner during intercourse (6 NR) and 89% achieved standing micturition (6 NR). Compared with RFFP, metoidioplasty was significantly more likely to be completed in a single stage, have an aesthetic result, maintain erogenous sensation, achieve standing micturition and have a lower overall complication rate. The authors reported that, although the current literature suggests that metoidioplasty is more likely to yield an "ideal" neophallus compared with RFFP, any conclusion is severely limited by the low quality of available evidence.

Using a retrospective chart review, Buncamper et al. (2016) assessed surgical outcome after penile inversion vaginoplasty. Outcome measures were intraoperative and postoperative complications, reoperations, secondary surgical procedures and possible risk factors. Of 475 patients who underwent the procedure, 405 did not have additional full-thickness skin grafts while 70 did have grafts. Median follow-up was 7.8 years. The most frequently observed intraoperative complication was rectal injury (2.3 percent). Short-term postoperative bleeding that required transfusion (4.8 percent), reoperation (1.5 percent) or both (0.4 percent) occurred in some cases. Major complications were three (0.6 percent) rectoneovaginal fistulas, which were successfully treated. Revision vaginoplasty was performed in 14 patients (2.9 percent). Comorbid diabetes was associated with a higher risk of local infection, and use of psychotropic medication predisposed to postoperative urinary retention. Successful vaginal construction without the need for secondary functional reoperations was achieved in the majority of patients.

Bouman et al. (2016) prospectively assessed surgical outcomes of primary total laparoscopic sigmoid vaginoplasty in 42 transgender women with penoscrotal hypoplasia. Mean follow-up time was 3.2 ± 2.1 years. The mean operative duration was 210 ± 44 minutes. There were no conversions to laparotomy. One rectal perforation was recognized during surgery and immediately oversewn without long-term consequences. The mean length of hospitalization was 5.7 ± 1.1 days. One patient died as a result of an extended-spectrum beta-lactamase-positive necrotizing fasciitis leading to septic shock, with multiorgan failure. Direct postoperative complications that needed laparoscopic reoperation occurred in three cases (7.1 percent). In seven cases (17.1 percent), long-term complications needed a secondary correction. After 1 year, all patients had a functional neovagina with a mean depth of 16.3 ± 1.5 cm.

Despite the significant increase in genital gender affirming surgery (GAS) within the past 50 years, there is limited data regarding hair removal practices in preparation for genital GAS. Genital gender affirming surgery (GAS) involves reconstruction of the genitals to match a patient's identified sex. The use of hair-bearing flaps in this procedure may result in postoperative intra-vaginal and intra-urethral hair growth and associated complications, including lower satisfaction with genital GAS. In 2016 Zhang et al conducted a literature review, recommendations from experience, and a practical laser hair removal (LHR) approach to hair removal prior to genital GAS.

Gaither et al. (2017) retrospectively reviewed the records of 330 MtF patients from 2011 to 2015, to assess surgical complications related to primary penile inversion vaginoplasty. Complications included granulation tissue, vaginal pain, wound separation, labial asymmetry, vaginal stenosis, fistula formation, urinary symptoms including spraying stream or dribbling, infection, vaginal fissure or vaginal bleeding. Median age at surgery was 35 years, and median followup in all patients was 3 months. The results showed that 95 of the patients presented with a postoperative complication with the median time to a complication being 4.4 months. Rectoneovaginal fistulas developed in 3 patients, and 30 patients required a second operation. Age, body mass index and hormone replacement therapy were not associated with complications. The authors concluded that penile inversion vaginoplasty is a relatively safe procedure. Most complications due to this surgery develop within the first 4 months postoperatively. Age, body mass index and hormone replacement therapy are not associated with complications and, thus, they should not dictate the timing of surgery.

Horbach et al. (2015) conducted a systematic review of vaginoplasty techniques in MtF individuals with gender dysphoria. Twenty-six studies were included (mostly retrospective case series of low to intermediate quality). Outcome of the penile skin inversion technique was reported in 1,461 patients and bowel vaginoplasty in 102 patients. Neovaginal stenosis was the most frequent complication in both techniques. Sexual function and patient satisfaction were overall acceptable, but many different outcome measures were used. Quality of life was only reported in one study. Comparison between techniques was difficult due to the lack of standardization. The authors concluded that the penile skin inversion technique is the most researched surgical procedure. Outcome of bowel vaginoplasty has been reported less frequently but does not seem to be inferior. The available literature is heterogeneous in patient groups, surgical procedure, outcome measurement tools and follow-up. There is a need for prospective studies with standardized surgical procedures, larger patient groups and longer follow-up periods. Uniformity in outcome measurement tools such as validated questionnaires and scores for sexual function and quality of life is mandatory for correct interpretation and comparability of data.

Bouman et al. (2014) conducted a systematic review of surgical techniques and clinical outcomes of intestinal vaginoplasty. Twenty-one studies were included (n=894). All studies had a retrospective design and were of low quality. Prevalence and severity of procedure-related complications were low. The main postoperative complication was introital stenosis, necessitating surgical correction in 4.1% of sigmoid-derived and 1.2% of ileum-derived vaginoplasties. Neither diversion colitis nor cancer was reported. Sexual satisfaction rate was high, but standardized questionnaires were rarely used. Quality of life was not reported. The authors concluded that prospective studies, using standardized measures and questionnaires, are warranted to assess functional outcomes and quality of life.

Murad et al. (2010) conducted a systematic review to evaluate the effects of hormone therapy on patients undergoing gender reassignment surgery. The authors identified 28 eligible studies, all of which were observational and most lacked controls. These studies enrolled 1833 participants with gender dysphoria (1093 MtF; 801 FtM). After gender

reassignment surgery, individuals reported improvement in gender dysphoria (80%), psychological symptoms (78%), sexual function (72%) and quality of life (80%). The authors concluded that very low quality evidence suggests that gender reassignment, that includes hormonal interventions, is likely to improve gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life.

Sutcliffe et al. (2009) systematically reviewed five individual procedures for MtF gender reassignment surgery: clitoroplasty, labiaplasty, orchiectomy, penectomy and vaginoplasty. Further evaluations were made of eight surgical procedures for FtM gender reassignment surgery: hysterectomy, mastectomy, metoidioplasty, phalloplasty, salpingo-oophorectomy, scrotoplasty/placement of testicular prostheses, urethroplasty and vaginectomy. Eighty-two published studies (38 MtF; 44 FtM) were included in the review. For MtF procedures, the authors found no evidence that met the inclusion criteria concerning labiaplasty, penectomy or orchiectomy. A large amount of evidence was available concerning vaginoplasty and clitoroplasty procedures. The authors reported that the evidence concerning gender reassignment surgery in both MtF and FtM individuals with gender dysphoria has several limitations including lack of controlled studies, lack of prospective data, high loss to follow- up and lack of validated assessment measures. Some satisfactory outcomes were reported, but the magnitude of benefit and harm for individual surgical procedures cannot be estimated accurately using the current available evidence.

Djordjevic et al. (2013) evaluated 207 patients who underwent single-stage metoidioplasty, comparing two different surgical techniques of urethral lengthening. The procedure included lengthening and straightening of the clitoris, urethral reconstruction and scrotoplasty with implantation of testicular prostheses. Buccal mucosa graft was used in all cases for dorsal urethral plate formation and joined with one of the two different flaps: longitudinal dorsal clitoral skin flap (n=49) (group 1) and labia minora flap (n=158) (group 2). The median follow-up was 39 months. The total length of reconstructed urethra ranged from 9.1 to 12.3 cm in group 1 and from 9.4 to 14.2 cm in group 2. Voiding while standing was significantly better in group 2 (93%) than in group 1 (87.82%). Urethral fistula occurred in 16 patients in both groups. Overall satisfaction was noted in 193 patients. The authors concluded that combined buccal mucosa graft and labia minora flap was the method of choice for urethroplasty in metoidioplasty, minimizing postoperative complications.

A single-arm study by Weigert et al. (2013) evaluated patient satisfaction with breasts and psychosocial, sexual and physical well-being after breast augmentation in MtF individuals with gender dysphoria. Thirty-five patients were asked to complete the BREAST-Q Augmentation module questionnaire before surgery, at 4 months and later after surgery. A prospective cohort study was designed and postoperative scores were compared with baseline scores. Responses indicated significant improvements in satisfaction with surgery (+59 points), psychosocial well-being (+48 points) and sexual well-being (+34 points). No significant changes were reported for physical well-being. This study has several limitations including lack of a control group and subjective measures.

In a non-randomized study, Dhejne et al. (2011) evaluated mortality, morbidity and criminal rates after gender reassignment surgery in 324 individuals (MtF n=191; FtM n=133). Random population controls (10:1) were matched by birth year and birth sex or reassigned final sex. The authors reported substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts and psychiatric hospitalizations in sex-reassigned individuals (both MtF/FtM) compared to a healthy control population. FtMs had a higher risk for criminal convictions.

World Professional Association for Transgender Health (WPATH)

WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, is an advocacy group devoted to transgender health. WPATH guidelines (2012) present eligibility and readiness criteria for transition-related treatment, as well as competencies of health care providers.

WPATH describes the transition from one gender to another in the following three stages:
- Living in the gender role consistent with gender identity
- The use of cross-sex hormone therapy after living in the new gender role for a least three months
- Gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months

Professional Societies

American College of Obstetrics and Gynecology (ACOG)

An ACOG committee opinion (2017) provides guidance on health care for transgender adolescents. The document makes the following recommendations regarding surgery:
- Obstetrician-gynecologists should understand gender identity and be able to treat transgender patients or refer them appropriately for medical and surgical therapeutic options.
- Surgical management for transgender male patients is typically reserved for patients 18 years and older.
- For transgender male patients, phalloplasty may be performed when the patient reaches the age of majority.
- Transgender female patients who choose to undergo surgery for a neovagina may have vaginoplasty after the age of majority.
- Transgender patients should be counseled about fertility and fertility preservation prior to surgical treatment.

A separate ACOG committee opinion (2011) provides guidance on health care for transgender individuals. The document makes the following recommendations regarding surgery:

- Obstetrician-gynecologists should assist or refer transgender individuals for routine treatment and screening as well as hormonal and surgical therapies.
- Hormonal and surgical therapies should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender persons.

Endocrine Society

Endocrine Society practice guidelines (Hembree et al., 2017) addressing endocrine treatment of gender-dysphoric/gender-incongruent persons makes the following recommendations regarding surgery for sex reassignment and gender confirmation:

- Suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country (Recommendation based on low quality evidence).
- A patient pursue genital gender-affirming surgery only after the mental health practitioner (MHP) and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being (Strong recommendation based on low quality evidence).
- Surgery is recommended only after completion of at least one year of consistent and compliant hormone treatment unless hormone therapy is not desired or medically contraindicated (Ungraded Good Practice Statement).
- The physician responsible for endocrine treatment medically clears individual for surgery and collaborates with the surgeon regarding hormone use during and after surgery (Ungraded Good Practice Statement).
- Recommend that clinicians refer hormone treated transgender individuals for genital surgery when (Strong recommendation based on very low quality evidence):
  - The individual has had a satisfactory social role change
  - The individual is satisfied about the hormonal effects
  - The individual desires definitive surgical changes
- Suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement (Recommendation based on very low quality evidence).

American Academy of Pediatrics (AAP)

In a 2018 policy statement entitled Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, the AAP states the following regarding surgery: Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults, they are occasionally pursued during adolescence on a case-by case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Gender reassignment surgeries are procedures, and therefore, not subject to FDA regulation. However, medical devices, drugs, biologics or tests used as a part of these procedures may be subject to FDA regulation. See the following website to search by product name: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed June 4, 2019)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does have a National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9). Local Coverage Articles (LCAs) also exist; refer to the LCAs for Gender Reassignment Services for Gender Dysphoria.
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POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

01/01/2020	**Applicable Codes**
	• Updated list of applicable CPT codes to reflect annual code edits:
	  ○ Added 15769, 15771, 15772, 15773, and 15774
	  ○ Removed 19304 and 20926
	Supporting Information
	• Archived previous policy version CS145.E

INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

EXHIBIT G

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

August 10, 2018

RUSSELL TOOMEY
[redacted]

Member ID: [redacted]
Date of Service: October 1, 2018

Dear Russell Toomey:

Dr. Tiffany Woods Karsten has asked Blue Cross Blue Shield of Arizona (BCBSAZ) to approve you for a laparoscopic total hysterectomy with removal of tubes and ovaries surgery (58571) for your health issue of transsexualism and gender identity disorder (F64.0 and F64.9) at Tucson Medical Center. This is called "precertification." Your benefit plan requires you to get precertification for some services. A BCBSAZ Medical Director has reviewed the health care records your provider submitted.

Based upon that review, we cannot approve this request because the laparoscopic total hysterectomy with removal of tubes and ovaries surgery, for your diagnosis of transsexualism and gender identity disorder is considered a gender reassignment surgery, which is a benefit exclusion. This finding is based on your benefit plan booklet on pages 56 & 57 under the heading of "**Exclusions and General Limitations**" which states:

10.1 Exclusions and General Limitations

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

- Gender reassignment surgery."

If you choose to get the laparoscopic total hysterectomy with removal of tubes and ovaries surgery, BCBSAZ will not cover the costs of this service.

You have the right to appeal this decision. If you or your doctor chooses to proceed with the appeal process, you may call the appeal line and fax any additional supporting information. Your treating doctor may request an expedited appeal depending on medical urgencies.

Please see the reverse side of this letter for the BCBSAZ appeal and grievance procedures. You may submit your appeal by calling, faxing or mailing your request to:

Medical Appeals and Grievances Department A116
Blue Cross Blue Shield of Arizona
P.O. Box 13466
Phoenix, AZ 85002-3466
Phone: (602) 544-4938 or (866) 595-5998
Fax: (602) 544-5601

Before appealing, a service determined not to be medically necessary is eligible for a peer to peer (PtoP) discussion. The treating provider may ask for a PtoP discussion. This may be done by calling the Office of the Medical Director at 602-864-4209 within 7 days from the date of this letter. PtoP discussions are not available for benefit exclusions, including, but not limited to:

- Investigational/Experimental decisions
- Out of Network requests for In-Network Level of Benefits
- Medication Doses outside of Federal Drug Administration (FDA) dosing levels

The Clinical Content you are receiving is confidential and proprietary information and is being provided to you solely as it pertains to the claim or the information request at issue. Under copyright law, the Clinical Content may not be copied, distributed, or otherwise reproduced. The Clinical Content is solely for use as a screening guide to assist in determining the medical appropriateness of health care services. All decisions about health care are strictly and solely the obligation and responsibility of a treating health care provider.

You also have the right to reasonable access to the medical records, InterQual medical criteria and any other information BCBSAZ used for this medical necessity benefit determination. BCBSAZ did not rely on any medical records except those furnished by your provider. If you would like a copy of these records or any documentation, please call us at the number above.

Sincerely,

Darren Deering, D.O.
Senior Medical Director

If you are hearing impaired (TDD), please call (602) 864-4823 or (800) 232-2345 ext.4823.

cc: TIFFANY WOODS KARSTEN MD
839 W CONGRESS ST
TUCSON AZ 85745

TUCSON MEDICAL CENTER
5301 E GRANT RD
TUCSON AZ 85712

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 877-475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, 602-864-2288, TTY/TDD 602-864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídílkidgo éí doodago Háída bíjá anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hólǫ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí koj' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 877-475-4799.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799
.[تماس حاصل نمایید.

Assyrian:
[illegible] Blue Cross Blue Shield of Arizona [illegible]
[illegible] 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคณ หรอคนทคณกาลงชวยเหลอมคาถามเกยวกบ Blue Cross Blue Shield of Arizona
คณมสทธทจะไดรบความชวยเหลอและขอมลในภาษา ของคณไดโดยไมมคาใชจาย พดคยกบลาม โทร 877-475-4799

EXHIBIT 3

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. **State of Arizona; Arizona Board of Regents, D/B/A University of Arizona**, a governmental body of the State of Arizona; et al., Defendants.	Case No.19-cv-00035-TUC-RM (LAB) **PLAINTIFF'S MOTION TO COMPEL PRODUCTION OF DOCUMENTS**

Plaintiff, Dr. Russell B. Toomey, on behalf of himself and the certified Classes ("Plaintiff"), hereby submits through the undersigned counsel the following Memorandum of Law in support of his Motion For Entry Of An Order Compelling The Production Of Documents (the "Motion") from the State Of Arizona, Andy Tobin, and Paul Shannon (collectively, the "State Defendants") in response to Plaintiff's First Request For Production Of Documents And Tangible Things, dated December 8, 2020 ("Request for Production," "Request" or "RFP"). This Motion and exhibits hereto are accompanied by the Transmittal Declaration of Christine K. Wee ("Wee Decl."), and Plaintiff's LRCiv 7.2(j)-(k) and 37.1 Statement ("Plaintiff's LRCiv Statement").

PRELIMINARY STATEMENT

Plaintiff's Request for Production seeks documents and information concerning the State Defendants' rationale for maintaining an exclusion for "gender reassignment surgery" (the "Exclusion") in the State of Arizona's self-funded health care plan (the "Plan"). As this Court has previously recognized, documents regarding "the thought processes and state of mind of the decision makers behind the exclusion . . . bear directly on the issue of intent," which is potentially an "indispensable element of Toomey's causes of action." (Doc. 187, p.5)

State Defendants have withheld certain documents responsive to Plaintiff's requests and relevant to the issue of intent on the grounds that these documents are protected from disclosure by the attorney-client privilege. The most recent iteration of the State Defendants' Privilege Log, served on May 10, 2021, asserts the attorney-client privilege with respect to eighty-five documents. (*See* Wee Decl. Ex. 9) Yet, State Defendants have waived attorney-client privilege with respect to legal advice they considered on the legality of the Exclusion, *i.e.*, whether ADOA was required by law to cover gender reassignment surgery. They have done so in two ways.

First, State Defendants have waived the attorney-client privilege by asserting and relying on legal advice as a defense to the charge that discriminatory intent did not motivate their decision to maintain the Exclusion, effectively placing this legal advice at issue. When a party relies on advice of counsel to defend or explain its conduct, it cannot assert the attorney-client privilege to shield that advice from discovery. *Chevron Corp. v. Pennzoil Co.*, 974 F.2d 1156, 1162-63 (9th Cir. 1992). By (i) using legal advice as an explanation for its rationale for the Exclusion, but (ii) withholding from Plaintiff the advice it allegedly relied on in maintaining the Exclusion, the State Defendants improperly attempt to use advice of counsel as both a sword and a shield. *Id.*

Second, and alternatively, State Defendants have waived attorney-client privilege by disclosing the substance of the legal advice. Voluntary disclosure of the content of a privileged attorney communication constitutes "waiver of the privilege as to all other such

communications on the same subject." *Weil v. Inv./Indicators, Research and Mgt., Inc.*, 647 F.2d 18, 24 (9th Cir. 1981). State Defendants have disclosed the legal advice that was allegedly provided to them regarding the legality of the Exclusion to both (i) the Governor's Office and (ii) the Plaintiff. Either disclosure is sufficient to effect a waiver.

BACKGROUND

A. The Factual Disputes At Issue In This Case

Plaintiff alleges that State Defendants' categorical exclusion of medically necessary gender-affirming surgery from the health plan for state employees violates Title VII and the Equal Protection Clause. In their Joint Status Report dated October 23, 2020, the parties agreed that one of the disputed factual questions in this case is "[w]hether the decision to exclude gender reassignment surgery in the Health Care Plan was actually motivated by a legitimate governmental interest." (Doc. 128, p. 11) Although Plaintiff argues that the Exclusion is facially discriminatory and violative of Title VII and the Equal Protection Clause (*See* generally Doc. 86), Magistrate Judge Bowman's Report & Recommendation regarding Plaintiff's Motion for a Preliminary Injunction also concluded that Plaintiff must prove discriminatory intent by the State Defendants to succeed on his claims. (Doc. 134, pp. 6-9) It is unsettled what standard the Court will ultimately apply to Plaintiff's claims, and therefore discovery about State Defendants' intent "concerns an indispensable element of Toomey's causes of action" and such "documents remain relevant." (Doc. 187, p. 5)

B. Defendants' Withholding of Documents Based on Attorney-Client Privilege

On December 8, 2020, Plaintiff served his Request for Production on State Defendants. (Wee Decl., Ex. 2) Request Nos. 1, 3, and 9 specifically sought documents and information concerning the Exclusion, and the decision-making behind it. On May 10, 2021, State Defendants furnished their most up-to-date privilege log ("Privilege Log", Wee Decl. Ex. 9) The Privilege Log withheld eighty-five documents on the basis of attorney-client privilege.

C. State Defendants Affirmatively Place Legal Advice At Issue

i. State Defendants' Interrogatory Responses

Throughout discovery, State Defendants have asserted that they maintained the Exclusion based on advice of counsel about its legality. In June 2020, Plaintiff propounded interrogatories asking State Defendants to "identify and describe all reasons why" the State of Arizona maintains the Exclusion. (Wee Decl., Ex. 4, No. 1) State Defendants responded that:

> The State of Arizona's self-funded health plan excludes coverage for gender reassignment surgery because the State concluded, under the law, that it was not legally required to change its health plan to provide such coverage under either Title VII of the Civil Rights Act or under the Equal Protection clause of the Fourteenth Amendment to the United States Constitution.

(Wee Decl., Ex. 5 at No. 1 (emphasis added)) Thus, State Defendants independently put at issue their understanding of the legality of the Exclusion at the time of decision-making[1] as a rationale for maintaining the Exclusion.[2]

Plaintiff's Interrogatory No. 4 asked State Defendants to "[i]dentify all persons who participated in formulating, adopting, maintaining, reviewing, approving, or deciding to continue" the Exclusion. (Wee Decl., Ex. 4, No. 4) State Defendants identified six individuals, three of whom are lawyers for the State, indicating that counsel were central to the decision-making regarding the Exclusion. ((Wee Decl., Ex. 5, No. 4)) Plaintiff's Interrogatory No. 7 asked State Defendants to identify "all research, studies, data, reports, publications, testimony, or other documents considered, reviewed, or relied on by

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[1] State Defendants' current position that the Exclusion is lawful is distinct from the understanding that the State Defendants had at the time of decision-making, which occurred in 2016. Because the State Defendants have pointed to their alleged understanding that the Exclusion was lawful in 2016 as a rationale for the Exclusion, Plaintiff in fairness must be able to probe the veracity of the legal advice relied upon.

[2] As Plaintiff is unable to review the State Defendants' communications with counsel however, Plaintiff also has reason to be skeptical of State Defendants' actual understanding of the legality of the Exclusion, and whether that understanding in fact motivated the decision to maintain the Exclusion in 2016.

Defendants relating to the [] Exclusion. . . ." (Wee Decl., Ex. 4, No. 7) State Defendants listed two memoranda they relied on in making this decision—one from Marie Isaacson to Mike Liburdi, dated August 3, 2016 regarding "Affordable Care Act § 1557," and another from outside legal counsel Fennemore Craig, P.C.to Marie Isaacson dated July 20, 2016, regarding "Summary and Implications of § 1557 and Transgender Coverage Requirements"—both of which, according to the State Defendants, "are covered by the attorney-client privilege." (Wee Decl., Ex. 5, No. 7)

ii. Deposition Testimony From State Defendants Witnesses

Plaintiff also inquired about State Defendants' rationale for the Exclusion in depositions of witnesses disclosed by State Defendants as having knowledge regarding the matter, including in depositions of Ms. Marie Isaacson, Director of the Benefits Service Division of the ADOA from 2015-2018, and Mr. Scott Bender, Plan Administration Manager of the ADOA from 2015-Present.[3] When counsel for Plaintiff and the Arizona Board of Regents ("ABOR") questioned Ms. Isaacson and Mr. Bender regarding the rationale for the Exclusion, both witnesses consistently pointed to advice of counsel as a rationale for maintaining the Exclusion. Indeed, they testified that the key reason for maintaining the Exclusion was because State Defendants were advised that it was lawful. (Wee Decl., Ex. 6 at 31:8-32:8 (testifying that "the deciding factor" for maintaining the Exclusion was "[w]hat was required by law for us to cover," and that "legal counsel" were among the "group who made the decision"); *id*., Ex. 7 at 167:12-168:3 (testifying that the "primary reason" for maintaining the Exclusion was that ADOA understood that it was "not required" by law to cover the benefit))

[3] Wee Decl., Ex. 5, No. 2 (identifying, among others, Ms. Isaacson and Mr. Bender as "persons with knowledge" of "the reasons" for maintaining the Exclusion).

D. State Defendants Voluntarily Disclosed Legal Advice

i. Disclosure of Legal Advice to Governor's Office In 2016

As noted above, State Defendants have asserted that they relied on two legal memoranda, dated August 3, 2016 ("August 2016 Memorandum") and July 20, 2016 ("July 2016 Memorandum"), in making the decision to maintain the Exclusion. (Wee Decl., Ex. 5, No. 7) State Defendants identified the August 2016 Memorandum as being submitted to the Governor's Office. (Wee Decl., Ex. 5, No. 7 ("Memorandum from Marie Isaacson to Mike Liburdi, General Counsel at the Governor's Office") Deposition testimony corroborates that both memoranda were shared with the Governor's Office in 2016. (Wee Decl., Ex. 6 at 39:8-17 (stating that written legal advice was shared with Governor's Office prior to meeting in 2016 where Exclusion was decided on)) Further, Ms. Isaacson disclosed the content of this legal advice to Ms. Christina Corieri, a representative of the Governor's Office, in telephone calls. (*Id*. at 42:12-18)

ii. Disclosure of Legal Advice During Isaacson Deposition

Additionally, during her March 26, 2021 deposition, Ms. Isaacson independently broached the subject of the legal advice that ADOA received when asked whether she had made any professional or personal recommendation on whether to maintain the Exclusion. (*Id.* at 18:16-25 ("No. . . . We sought legal counsel regarding what was required.")) Ms. Isaacson then voluntarily disclosed, without objection from State Defendants' counsel, the substance of the legal advice provided to State Defendants regarding the Exclusion in 2016. Specifically, Ms. Isaacson disclosed that State Defendants were advised by counsel that "some services" were required to be covered, but gender reassignment surgery in particular was "not required to be covered." (*Id.* at 19:6-24)

E. Parties Meet And Confer

On April 28, 2021, Plaintiff sent State Defendants a letter advising them that State Defendants had waived attorney-client privilege with respect to legal advice they received regarding the legality of the Exclusion by both (i) placing the legal advice at issue and (ii) disclosing the legal advice. (Wee Decl. Ex. 8) On May 5, 2021, counsel for Plaintiff met and

conferred with counsel for State Defendants, who advised counsel for Plaintiff that they disagreed with the arguments raised in Plaintiff's April 28 letter. (Wee Decl. Ex. 1, Declaration of Jordan C. Wall ("Wall Decl.") ¶¶ 5-6) During this meet and confer, counsel for Plaintiff also argued that State Defendants' sharing of legal advice with the Governor's Office amounted to a waiver. (*Id*. at ¶ 7)

On May 10, 2021, State Defendants sent Plaintiff an email, again reiterating that they did not believe any wavier had occurred. (Wee Decl. Ex. 10) State Defendants argued that sharing legal advice with the Governor's Office did not amount to waiver because such communications were protected by the common interest doctrine. (*Id*.) On May 14, 2021, Plaintiff responded by email, informing State Defendants that it generally disagreed with their positions, and that given the parties' differences, it expected to seek this Court's intervention. (Wee Decl. Ex. 12) At a subsequent meet and confer on May 18, 2021, State Defendants agreed that the parties had reached an impasse. (Wall Decl. ¶ 12)

ARGUMENT

A party "may obtain discovery regarding any nonprivileged matter that is relevant to any party's claim or defense and proportional to the needs of the case." Fed. R. Civ. P. 26(b)(1); *Ocean Garden Prods. Inc. v. Blessings Inc.*, No. CV-18-00322-TUC-RM, 2020 WL 4284383, at *1-2 (D. Ariz. July 27, 2020) (Márquez, J.) (discovery may be compelled when a respondent unjustifiably objects to the production of responsive documents). Attorney-client privilege protects only "confidential communications between attorneys and clients, which are made for the purpose of giving legal advice." *United States v. Sanmina Corp.*, 968 F.3d 1107, 1116 (9th Cir. 2020). Because the privilege "impedes full and free discovery of the truth, the attorney-client privilege is strictly construed." *Weil v. Inv./Indicators, Rsch. & Mgmt., Inc.*, 647 F.2d 18, 24 (9th Cir. 1981). The burden of establishing attorney-client privilege "rests not with the party contesting the privilege, but with the party asserting it," as is the case with all evidentiary privileges claimed. *Id.* at 25. One of the elements that the party asserting attorney-client privilege must prove is that it has not waived the privilege. *Id.; Sanmina Corp*., 968 F.3d at 1116.

I. STATE DEFENDANTS HAVE WAIVED ATTORNEY-CLIENT PRIVLEGE BY ASSERTING THE ADVICE OF COUNSEL TO DEFEND THEIR RATIONALE FOR THE EXCLUSION

The doctrine that "protects attorney-client communications may not be used both as a sword and a shield." *Melendres v. Arpaio*, CV-07-2513-PHX-GMS, 2015 WL 12911719, at *2 (D. Ariz. May 14, 2015) (quoting *Chevron Corp. v. Pennzoil Co.*, 974 F.2d 1156, 1162 (9th Cir. 1992) (internal adjustments omitted)). A party asserting the advice of legal counsel to defend its motivation or intent in taking certain action, cannot then assert the attorney-client privilege to shield that advice from discovery. *Chevron Corp.*, 974 F.2d at 1162-63 (finding defendant waived attorney-client privilege by relying on legal advice to support reasonableness of actions). The Ninth Circuit has adopted a three-prong test to evaluate whether a party has waived the attorney-client privilege due to the offensive use of the privilege:

> First, the court considers whether the party is asserting the privilege as the result of some affirmative act, such as filing suit . . . Second, the court examines whether through this affirmative act, the asserting party puts the privileged information at issue. . . . Finally, the court evaluates whether allowing the privilege would deny the opposing party access to information vital to its defense.

United States v. Amlani, 169 F.3d 1189, 1195 (9th Cir. 1999) (internal citations and quotations omitted); *see also Chevron Corp.*, 974 F.2d at 1162-63. Here, all three prongs are satisfied.

First, State Defendants have affirmatively asserted advice of counsel in defense of their motivation for maintaining the Exclusion. State Defendants affirmatively cited their understanding that ADOA was not required to cover gender reassignment surgery as a rationale for the Exclusion in their response to written discovery. (Wee Decl., Ex. 5 at No. 1) State Defendants' responses to written discovery also assert that counsel was centrally involved in the now-in-question decision-making regarding the Exclusion. (*Id.* at No. 4) Further, testimony from witnesses identified and offered by State Defendants who were directly involved in the decision-making on the Exclusion, specifically Ms. Isaacson and

Mr. Bender, supports that the legal advice of counsel on the legality of the Exclusion was a predominate, if not the sole, rationale for maintaining the Exclusion. (Wee Decl., Ex. 6 at 31:8-32:8; *id*., Ex. 7 at 167:12-168:3) As such, State Defendants have affirmatively placed legal advice, and their alleged understanding of their legal obligations, front and center in the present dispute over intent.

Contrary to the State Defendant's assertion, (Wee Decl., Ex.10), a party need not formally plead an advice of counsel defense in order to affirmatively place legal advice at issue. Courts in the Ninth Circuit have found that a party can affirmatively place legal advice at issue during discovery through witness testimony or a declaration, where the party—in *substance* if not in form—relies on advice of counsel to defend or explain its actions. *See Chevron,* 974 F.2d at 1162-63 (finding that defendant placed advice at issue during discovery when it submitted a declaration saying that its decision to make a particular investment was reasonable because it was made based on advice of counsel); *Melendres*, 2015 WL 12911719 at *4 (finding that privileged information was placed at issue by defendant "testifying about its reliance on advice of defense counsel.") Moreover, the State Defendant's form-over-substance argument—that a party must plead an advice of counsel defense in order to put legal advice at issue—has been flatly rejected by the Arizona Supreme Court, which reasoned that neither Arizona state nor federal jurisprudence support such a restriction. *See State Farm Mut. Auto. Ins. Co. v. Lee*, 13 P.3d 1169, 1175-77 (Ariz. 2000) (citing federal and Arizona case law on wavier of attorney-client privilege and holding that an express advice of counsel defense is not required to waive the privilege).

Second, State Defendants' affirmative reliance on legal advice as a rationale for maintaining the Exclusion places otherwise privileged information squarely at issue in the present dispute regarding intent behind the Exclusion. Where a party explains the motivation for its conduct by maintaining that it believed its actions were legal, it affirmatively places its "knowledge of the law and the basis for [its] understanding of what the law requires in issue." *Chevron*., 974 F.2d at 1162 (internal quotations omitted).

The Ninth Circuit's decision in *Chevron* is instructive. In *Chevron*, the plaintiff's claims centered around the defendant's motivation for entering into an investment, specifically whether the defendant intended to obtain control over plaintiff at the time of the relevant investment. *See id.* at 1157. The defendant asserted—by submitting a declaration during discovery—that its investment was reasonable and not intended to obtain control of the plaintiff "because it was based on the advice of counsel." *Id.* at 1162-1163. The Ninth Circuit held that, by affirmatively relying on legal advice to explain the intent of its action, the defendant had "put[] at issue the [legal] advice it received," and thus waived the attorney-client privilege. *Id.*

Similarly, State Defendants' affirmative claim that the Exclusion is non-discriminatory because they understood the Exclusion to be lawful at the time it was implemented based on the advice of counsel necessarily puts at issue the State Defendant's actual understanding of the lawfulness of the Exclusion at the time of decision-making. *See id.* In order to be able to evaluate the veracity of the State Defendants' allegations regarding their understanding of the law as a rationale for the Exclusion, Plaintiff and the Court must be able to see the advice State Defendants considered in maintaining the Exclusion. State Defendants "cannot invoke the attorney-client privilege to deny [Plaintiff] access to the very information that [Plaintiff]" needs in order to evaluate State Defendants' purported rationale. *See id.* at 163.

Third, the information being withheld by State Defendants is vital to the case, as it goes to the heart of State Defendants' rationale for maintaining the Exclusion. This Court has recently recognized that the issue of State Defendants' rationale for the Exclusion remains a live and critical one. (Doc. 187, at 5) The information being withheld is especially critical in the present dispute, because State Defendants rely almost exclusively on advice of counsel in explaining their rationale for the Exclusion.[4] Fairness strongly supports that

[4] State Defendants cite cost as another non-discriminatory basis for maintaining the Exclusion, but the salience of this rationale has been undermined by the State's own witnesses. (*See, e.g.*, Wee Decl., Ex. 6 at 31:8-15 (Marie Isaacson testifying that cost

State Defendants not be allowed to withhold documents and communications regarding this legal advice. *See Arizona ex rel. Goddard v. Frito-Lay, Inc.,* 273 F.R.D. 545, 557 (D. Ariz. 2011) (finding that out of fairness, a government agency cannot "bolster" a determination it makes by citing a legal conclusion, "and at the same time claim the attorney-client privilege in how it arrived at the conclusion."); *Chevron*, 974 F.2d at 1162-63; *Melendres*, 2015 WL 12911719 at *4; *Amlani*, 169 F.3d at 1196.

II. STATE DEFENDANTS HAVE WAIVED ATTORNEY-CLIENT PRIVLEGE BY DISCLOSING ADVICE Of COUNSEL

Alternatively, State Defendants waived the attorney-client privilege by (1) disclosure to the Arizona Governor's Office in 2016 and (2) disclosure during Ms. Isaacson's March 2021 deposition, without objection from counsel.

A. Waiver By Sharing Legal Advice With Governor's Office

"[V]oluntarily disclosing privileged documents to third parties will generally destroy the privilege." *Sanmina Corp*., 968 F.3d at 1116 (internal citations omitted). Here, the State Defendants waived the attorney-client privilege when they voluntarily shared privileged information with the Governor's Office regarding the Exclusion, both through sharing the July 2016 Memorandum and the August 2016 Memorandum, as well as discussing such advice telephonically and during the October 2016 meeting. State Defendants have maintained throughout this litigation that the Governor's Office is a third party, distinct from ADOA, and even directed Plaintiff to serve a third-party subpoena to obtain documents from the Governor's Office. (Wee Decl., Ex. 2 at No. 8, objecting to production of documents in possession of Governor's Office) To that end, the State Defendants and the Governor's Office retained separate counsel with respect to this litigation—implying that the two entities understand themselves as separate, with distinct, incongruent interests regarding the

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was not "the driving factor" in ADOA's decision, and that instead legal advice that ADOA was not required to cover gender reassignment surgery was the principal rationale); *Id.*, Ex. 7 at 167:12-168:3 (Scott Bender testifying that cost was secondary, and that advice about what ADOA was required or not required to cover was the primary basis of ADOA's decision))

Exclusion.

State Defendants have also incorrectly argued that the common interest doctrine protects their sharing of privileged information with the Governor's Office, preventing any waiver. (Wee Decl., Ex. 10) The common interest doctrine only applies however "when attorneys exchang[e] confidential communications from clients who are or potentially may be codefendants or have common interests in litigation." *Sapphire Sales Sols., LLC v. Best W. Intl., Inc*., CV-12-01538-PHX-ROS, 2013 WL 12284534, at *2 (D. Ariz. June 27, 2013) (emphasis added). The shared material must also be made in pursuit of some joint strategy—whether written or unwritten. *In re Pac. Pictures Corp.,* 679 F.3d at 1129 (9th Cir. 2012). State Defendants have offered no evidence that either they or the Governor's Office had contemplated any imminent or potential litigation when they exchanged privileged information evaluating the Exclusion in 2015/16, or even soon after. Ms. Isaacson, who testified that she was present during conversations with the Governor's office, specifically stated that discussions with the Governor were not related to any lawsuit, but instead concerned "coverage of transgender benefits." (Wee Decl., Ex. 6 at 72:16-22; *id.* 179:24-180:1) This litigation itself was not filed until much later, on January 3, 2019.

Even if litigation had been contemplated, State Defendants' and the Governor's Office's supposed shared interest in the outcome of this litigation alone does not warrant application of the common interest doctrine. *In re Pac. Pictures Corp.*, 679 F.3d at 1129 ("[A] shared desire to see the same outcome in a legal matter is insufficient to bring a communication between two parties within this exception") (citation omitted). There must have been some coordination of strategy in anticipation of litigation at the time the privileged information was shared to permit application of the common interest doctrine. Rather, the privileged material appears to have been shared between principals for the ADOA and the Governor's Office for the purposes of making changes to the Plan's design, not for purposes of an existing or imminent lawsuit, and State Defendants—who have the burden of proving that no wavier has occurred—have provided no authority to support that such general policymaking conversations are protected by the common interest privilege. *See Sanmina*

Corp., 968 F.3d at 1116 (party asserting privilege has burden to establish that waiver has not occurred).

B. Wavier By Disclosing Legal Advice During Isaacson Deposition

Waiver by disclosure occurs during a deposition when a witness voluntarily discloses legal advice. *See Weil*, 647 F.2d at 24 (finding waiver where party disclosed substance of the legal advice during deposition); *see also Thomas v. F.F. Fin., Inc*., 128 F.R.D. 192, 192-94 (S.D.N.Y. 1989) (finding subject matter waiver where a party disclosed information about legal representation during deposition). The objective fact of such voluntary disclosure, without objection of counsel, and in the absence of surprise or deception, may be sufficient to rule on the question of waiver. *Weil*, 647 F.2d. at 25 n. 13.

During her deposition, Ms. Isaacson forthrightly disclosed some of the content of legal advice received by State Defendants regarding the legality of the Exclusion, *i.e.*, that "some services" had to be covered, but not gender reassignment surgery. (Wee Decl., Ex. 6 at 19:6-24) As noted above, Ms. Isaacson independently disclosed this legal advice without prompting from the examining counsel, and without timely objection from counsel. *Id.* This disclosure amounts to waiver. *Sanmina Corp*., 968 F.3d at 1116. Privilege is not saved, as State Defendants have suggested, by the fact the specific legal advice was not disclosed; it is enough that Ms. Isaacson disclosed the *content* of the attorney-client communications. (*See* Wee Decl., Ex. 6 at 19:06-24) See *Sanmina Corp*., 968 F.3d at 1123-24 (holding that "voluntary disclosure of the content of a privileged attorney communication constitutes waiver") (quoting *Weil*, 647 F.2d. at 24)

Because waiver by State Defendants happened via disclosure, it amounted to a waiver "as to all other communications on the same subject." *Hernandez*, 604 F.3d at 1100. The subject of the disclosed advice was on the legality of the Exclusion, *i.e*., whether ADOA was required by law to cover gender reassignment surgery. *See* Wee Decl., Ex. 6 at 19:18-24. Therefore, any privilege claimed over documents containing legal advice regarding whether ADOA was required by law to cover gender reassignment surgery at the time of decision-making has been waived.

CONCLUSION

For all the reasons discussed above, Plaintiff's Motion should be granted.

Respectfully submitted this 20th day of May, 2021.

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CERTIFICATE OF SERVICE

I hereby certify that on May 20, 2021, I electronically transmitted the attached document to the Clerk's office using the CM/ECF System for filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system.

/s/ *Christine K. Wee*
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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. **State of Arizona; Arizona Board of Regents, D/B/A University of Arizona**, a governmental body of the State of Arizona; et al., Defendants.	Case No.19-cv-00035-TUC-RM (LAB) **PLAINTIFF'S LRCIV STATEMENT**

Pursuant to Local Rule of Civil Procedure 7.2(j)-(k), and 37.1(a), Plaintiff Russell B. Toomey ("Plaintiff") hereby submits the following statement ("Plaintiff's LRCiv Statement") in support of his Motion to Compel Production of Documents (the "Motion").

FACTUAL BACKGROUND

On June 5, 2020, Plaintiff served his First Set of Interrogatories ("Interrogatories") upon Defendants State of Arizona, Andy Tobin, and Paul Shannon (hereinafter the "State Defendants"). On September 28, 2020, State Defendants served answers and objections to Plaintiff's Interrogatories. On January 21, 2021, State Defendants served their First Supplemental Responses to Plaintiff's Interrogatories.

On December 8, 2020, Plaintiff served his First Request for Production of Documents and Tangible Things ("Request for Production", "Request", or "RFP") upon State Defendants. On January 21, 2021, State Defendants served responses and objections to

Plaintiff's Request for Production. Since the time State Defendants served their response to Plaintiff's Request to Produce Documents, State Defendants have provided three separate "final" privilege logs, most recently on May 10, 2021 (hereinafter "Privilege Log"). Per the Privilege Log, State Defendants, without basis, withhold production of [85] documents on the basis, in whole or in part, of the attorney-client privilege.

LRCIV 7.2(J) STATEMENT

On May 5, 2021, and again on May 18, 2021, counsel for the Plaintiff and the State Defendants (collectively, the "Parties") met and conferred by telephonic conference on several topics, including the subject of waiver of attorney-client privilege. At the conferences, Plaintiff reiterated their objections to State Defendants' assertion of the attorney-client privilege, on the basis of waiver. The Parties also engaged in written correspondence regarding the State Defendants' assertion of attorney-client privilege. Counsel are agreed that the Parties had made a sincere effort in good faith to resolve or narrow the dispute concerning State Defendants' waiver of attorney-client privilege, but the Parties have been unable to do so.

LRCIV 37.1 STATEMENT

1. Plaintiff's Request for Production No. 1

(1) **Request**: "Please produce all documents related to the Plan's current or prior Transgender Healthcare Exclusion, including, but not limited to: (a) all draft and previous version of the Transgender Healthcare Exclusion, including the earliest iteration of the Transgender Healthcare Exclusion, and any attachments or supplement thereto (whether actual or proposed); (b) all documents (to include any formal or informal financial or budgetary or other analyses, actuarial reports, or other reports or memoranda) and communications between Defendants and all internal and external persons (including, but not limited to, any insurance company, any consultant, the Alliance Defending Freedom, the Center for Arizona Policy, or any lobbying or interest group regarding whether any form or transition-related care or the Transgender Health Exclusion should

be adopted, modified, retained, or eliminated, and the rationale provided or discussed; (c) all documents and communications with internal and external persons pertaining to Defendants' initial decision to exclude transition-related or the Transgender Health Exclusion, including minutes or recordings of meetings where coverage for or exclusion of any form of transition-related care was discussed."

(2) **Response**: "The State Defendants object to Request For Production No. 1 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the scope of the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration. Subject to and without waiving the foregoing objections, the State Defendants respond as follows: The State Defendants will produce non-privilege documents responsive to Request For Production No. 1 in the possession, custody, and control of the Arizona Department of Administration. The State Defendants are not in possession, custody, or control of any Health Plan Documents prior to 2005.

(3) **Deficiency**: State Defendants' responses and objections are deficient because they improperly cite attorney-client privilege as a basis for withholding documents from production, when such privilege has been waived. First, State Defendants placed their attorney-client communications at-issue by relying on

the same as a reasonable basis to maintain the State Defendant's exclusion of gender reassignment surgery (the "Exclusion") in the State of Arizona's self-funded healthcare plan. As such, the interests of fairness preclude State Defendants from withholding any documents relating to the advice received regarding the legality of the Exclusion. Second, State Defendants expressly waived the privilege by disclosing the contents of the same (i) to the Office of the Arizona Governor (the "Governor's Office") in 2016 and (ii) to Plaintiff during the deposition testimony of Marie Isaacson, former Director of the Arizona Department of Administrations ("ADOA") Benefits Services Division. Third, in all events, the privilege should be overcome because the need for accurate fact-finding overcomes the privilege.

2. Plaintiff's Request for Production No. 3

(1) **Request**: "Please produce all versions and iterations of the Plan's policies/lists of Exclusions and General Limitations (*e.g.*, Article 9.1 of ADOA's PPO and EPO Plans, Article 10.1 of ADOA's HAS Plan) from the years 2010 through present, as well as all documents and communications between Defendants and internal or external persons regarding creating, amending, continuing, or eliminating any exclusion of coverage contained in any version/iteration of the Plan's Exclusions and General Limitations policy, including, but not limited to, the potential costs of enforcing, amending, or eliminating such coverage, the medical necessity, safety, and efficacy (including whether a procedure is deemed experimental or cosmetic) of excluded treatments and services; or the public health effects of enforcing, amending, or eliminating such excluded coverage. Such documents should include any and all actuarial reports, analyses, or memorandums pertaining to such exclusions of coverage."

(2) **Response**: "The State Defendants object to Request For Production No. 3 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs of State Defendants. The State Defendants

further object that the Request is vague and ambiguous as to the term "medical necessity." The State Defendants further object that the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks information which is duplicative of Request for Production No. 1. The State Defendants further object that the Request seeks information which is neither relevant nor reasonably related to any claim or defense in this matter. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory, and/or common law privacy of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within its possession, custody, and control of the Arizona Department of Administration. Subject to and without waiving the foregoing objections, the State Defendants respond as follows: The State Defendants will produce copies of the Health Plans from 2010 to present."

(3) **Deficiency**: State Defendants' responses and objections are deficient because they improperly cite attorney-client privilege as a basis for withholding document from production, when such privilege has been waived. First, State Defendants placed their attorney-client communications at-issue by relying on the same as a reasonable basis to maintain the Exclusion. As such, the interests of fairness preclude State Defendants from withholding any documents relating to the advice received regarding the legality of the Exclusion. Second, State Defendants expressly waived the privilege by disclosing the contents of the same (i) to the Governor's Office in 2016 and (ii) to Plaintiff during the deposition testimony of Marie Isaacson, former Director of the ADOA Benefits

Services Division. Third, in all events, the privilege should be overcome because the need for accurate fact-finding overcomes the privilege.

3. Plaintiff's Request for Production No. 6

(1) **Request**: "Please produce documents sufficient to show, from 2010 to present: (a) the number of hysterectomies paid for by the Plan each year, the medical reason for the surgery, and the individual and aggregate cost of the surgeries; and (b) the number of medically necessary cosmetic or reconstructive surgical procedures paid for by the Plan each year (including but not limited to chest-reconstruction surgery, vaginoplasty, or phalloplasty, or other surgery related to the reproductive or urogenital system) the medical reason for the surgery, and the individual and aggregate cost of the surgeries."

(2) **Response**: "The State Defendants object to Request For Production No. 6 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request is vague and ambiguous as to the terms "medically necessary," "cosmetic," and "reconstructive" procedures. The State Defendants further object that the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks information which is neither relevant nor reasonably related to any claim or defense in this matter to the extent it is seeking information regarding medical treatment and/or services other than for gender transition surgery. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the doctor-patient privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory, and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within

the possession, custody, and control of the Arizona Department of Administration."

(3) **Deficiency**: State Defendants' responses and objections are deficient because they improperly cite attorney-client privilege as a basis for withholding document from production, when such privilege has been waived. First, State Defendants placed their attorney-client communications at-issue by relying on the same as a reasonable basis to maintain the Exclusion. As such, the interests of fairness preclude State Defendants from withholding any documents relating to the advice received regarding the legality of the Exclusion. Second, State Defendants expressly waived the privilege by disclosing the contents of the same (i) to the Governor's Office in 2016 and (ii) to Plaintiff during the deposition testimony of Marie Isaacson, former Director of the ADOA Benefits Services Division. Third, in all events, the privilege should be overcome because the need for accurate fact-finding overcomes the privilege.

4. Plaintiff's Request for Production No. 9

(1) **Request**: "Please produce all document supporting Your responses to Plaintiff's First set of Interrogatories provided to Defendants on June 5, 2020."

(2) **Response**: "The State Defendants object that Request For Production No. 9 is vague and ambiguous as to what documents "support" the State Defendants' responses. The State Defendants further object to the Request on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the doctor-patient privilege, the work product doctrine, deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory, and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent

that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration. Subject to and without waiving the foregoing objections, the State Defendants respond as follows: The State Defendants have already produced non-privileged documents responsive to Request for Production No. 9 in the possession, custody, and control of the Arizona Department of Administration."

(3) **Deficiency**: State Defendants' responses and objections are deficient because they improperly cite attorney-client privilege as a basis for withholding document from production, when such privilege has been waived. First, State Defendants placed their attorney-client communications at-issue by relying on the same as a reasonable basis to maintain the Exclusion. As such, the interests of fairness preclude State Defendants from withholding any documents relating to the advice received regarding the legality of the Exclusion. Second, State Defendants expressly waived the privilege by disclosing the contents of the same (i) to the Governor's Office in 2016 and (ii) to Plaintiff during the deposition testimony of Marie Isaacson, former Director of the ADOA Benefits Services Division. Third, in all events, the privilege should be overcome because the need for accurate fact-finding overcomes the privilege.

Dated this 20th day of May, 2021.

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CERTIFICATE OF SERVICE

I hereby certify that on May 20, 2021, I electronically transmitted the attached document to the Clerk's office using the CM/ECF System for filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system.

/s/ *Christine K. Wee*
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Attorneys for Plaintiff Russell B. Toomey

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. **State of Arizona; Arizona Board of Regents, D/B/A University of Arizona**, a governmental body of the State of Arizona; et al., Defendants.	Case No.19-cv-00035-TUC-RM (LAB) **DECLARATION OF CHRISTINE K WEE IN SUPPORT OF PLAINTIFF'S MOTION TO COMPEL PRODUCTION OF DOCUMENTS**

I, Christine K. Wee, submit this declaration under penalty of perjury pursuant to 28 U.S.C. § 1746 and declare as follows:

1. I am a Senior Staff Attorney at ACLU Foundation of Arizona, licensed to practice law in the State of Arizona, and represent Plaintiff Russell B. Toomey ("Dr. Toomey" or "Plaintiff").

2. I submit this declaration in support of Plaintiff's Motion for Entry of an Order Compelling the Production of Documents.

3. I base this declaration on my personal knowledge and on information obtained in the course of the above-captioned matter.

4. **Exhibit 1** as attached to Plaintiff's Motion is a true and correct copy of Jordan C. Wall's supplemental declaration, dated May 19, 2021.

5. **Exhibit 2** as attached to Plaintiff's Motion is a true and correct copy of Plaintiff's First Request for Production, dated December 8, 2020.

6. **Exhibit 3** as attached to Plaintiff's Motion is a true and correct copy of State Defendants' Responses to Plaintiff's First Request for Production, dated January 21, 2021.

7. **Exhibit 4** as attached to Plaintiff's Motion is a true and correct copy of Plaintiff's First Set of Interrogatories, dated June 5, 2020.

8. **Exhibit 5** as attached to Plaintiff's Motion is a true and correct copy of State Defendants' Supplemental Response to Plaintiff's First Set of Interrogatories, dated January 21, 2021.

9. **Exhibit 6** as attached to Plaintiff's Motion is a true and correct copy of excerpts of the Marie Isaacson Deposition Transcript, dated March 26, 2021.

10. **Exhibit 7** as attached to Plaintiff's Motion is a true and correct copy of excerpts of the Scott Bender Deposition Transcript, dated March 31, 2021.

11. **Exhibit 8** as attached to Plaintiff's Motion is a true and correct copy of Plaintiff's April 28, 2021 letter to State Defendants.

12. **Exhibit 9** as attached to Plaintiff's Motion is a true and correct copy of State Defendants' Privilege Log served May 10, 2021.

13. **Exhibit 10** as attached to Plaintiff's Motion is a true and correct copy of State Defendants' May 10, 2021 email to Plaintiff.

14. **Exhibit 11** as attached to Plaintiff's Motion is a true and correct copy of State Defendants' May 14, 2021 letter to Plaintiff.

15. **Exhibit 12** as attached to Plaintiff's Motion is a true and correct copy of State Defendants' May 14, 2021 email to Plaintiff.

16. **Exhibit 13** as attached to Plaintiff's Motion is a true and correct copy of Plaintiff's May 17, 2021 email to State Defendants.

I declare under penalty of perjury that the foregoing is true is and correct.

Executed this 20th day of May, 2021.

/s/ Christine K. Wee
Christine K. Wee

EXHIBIT 1

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Attorneys for Plaintiff Russell B. Toomey

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona; Arizona Board of Regents, D/B/A University of Arizona, a governmental body of the State of Arizona; et al.,

Defendants.

Case No.19-cv-00035-TUC-RM (LAB)

DECLARATION OF JORDAN C. WALL IN SUPPORT OF PLAINTIFF'S MOTION TO COMPEL PRODUCTION OF DOCUMENTS

I, JORDAN C. WALL, declare as follows:

1. I am a Senior Associate at Willkie Farr & Gallagher LLP, and represent Plaintiff Russell B. Toomey.

2. I submit this declaration in support of Plaintiff's Motion For Entry Of An Order Compelling The Production Of Documents, filed with this Court on May 19, 2021, together with this declaration.

3. I base this declaration on my own personal knowledge and on information obtained in the course of the above-captioned matter.

4. On April 28, 2021, Plaintiff served on State Defendants a letter regarding discovery. (Mot. Ex. 8) In that letter, Plaintiff informed State Defendants that State Defendants were improperly withholding certain documents on the basis of attorney-client privilege. Specifically, Plaintiff informed State Defendants that they had waived the

attorney-client privilege by (i) putting legal advice received regarding the Exclusion[1] at issue and (ii) disclosing legal advice regarding the legality of the Exclusion[2] to the Plaintiff during the deposition of Marie Isaacson.

5. During a meet and confer held on May 5, 2021, the parties discussed Plaintiff's bases for waiver. Specifically, State Defendants first argued during the May 5, 2021 meet and confer that they did not place the privileged information at-issue. State Defendants stated that the privileged information is not at-issue because State Defendants did not formally cite advice of counsel as an affirmative defense. State Defendants also argued that the attorney-client privilege was not waived because Marie Isaacson allegedly did not have authority to waive any privilege belonging to the State Defendants.

6. State Defendants asserted that they did not agree with any of Plaintiffs' asserted bases for wavier.

7. During the parties' May 5, 2021 meet and confer, Plaintiff also argued that State Defendants had waived the attorney-client privilege by sharing legal advice with the Arizona Governor's Office in 2016, after State Defendants had held the Arizona Governor's Office out as a separate entity and a non-party to the present litigation.

8. On May 10, 2021, State Defendants emailed Plaintiff regarding waiver of the attorney-client privilege, again asserting that State Defendants did not agree with any of Plaintiff's alleged bases for waiver. Regarding wavier by sharing the Arizona Governors' Office, State Defendants maintained that sharing attorney-client privileged information between the State Defendants and the Governor's Office was protected by the common interest doctrine.

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[1] Unless otherwise specified, defined terms used in this declaration have the same meaning as those terms defined in the Memorandum of Law In Support of Plaintiff's Motion For Entry Of An Order Compelling The Production of Documents, filed together with this declaration.

9. On May 14, 2021, Plaintiff responded to State Defendants' email, explaining that counsel had reviewed the arguments therein, disagreed, and maintained that State Defendants' had waived attorney-client privilege on several grounds.

10. That same day, State Defendants' responded to Plaintiff, requesting, among other things, a further meet and confer to discuss Plaintiff's arguments regarding waiver based on the sharing of privileged information with the Governor's Office.

11. On May 15, 2021, Plaintiff reiterated his belief that the parties had reached an impasse on the waiver issue, but agreed to a further meet and confer if State Defendants sincerely believed the parties could resolve their dispute. On May 17, 2021, Plaintiff offered to meet and confer the following day on the waiver issue, among other topics.

12. On May 18, 2021, the parties met and conferred once more, including on the topic of waiver of attorney-client privilege. They were unable to resolve their dispute, and agreed that resort to the Court would be necessary.

I declare under penalty of perjury, in accordance with 28 U.S.C. § 1746, that the foregoing is true is and correct.

Executed this 19th day of May, 2021.

/s/ *Jordan C. Wall*
Jordan C. Wall

EXHIBIT 2

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Attorneys for Plaintiff Russell B. Toomey

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,

Plaintiff,

v.

STATE OF ARIZONA; ARIZONA BOARD OF REGENTS, D/B/A UNIVERSITY OF ARIZONA, a governmental body of the State of Arizona; **RON SHOOPMAN**, in his official capacity as chair of the Arizona Board Of Regents; **LARRY PENLEY**, in his official capacity as Member of the Arizona Board of Regents; **RAM KRISHNA**, in his official capacity as Secretary of the Arizona Board of Regents; **BILL RIDENOUR**, in his official capacity as Treasurer of the Arizona Board of Regents; **LYNDEL MANSON**, in her official capacity as Member of the Arizona Board of Regents; **KARRIN TAYLOR ROBSON**, in her official capacity as Member of the Arizona Board of Regents; **JAY HEILER**, in his official capacity as Member of the Arizona Board of Regents; **FRED DUVAL**, in his official capacity as Member of the Arizona Board of Regents; **ANDY TOBIN**, in his official capacity as Director of the Arizona Department of Administration; **PAUL SHANNON**, in his official capacity as Acting Assistant Director of the Benefits Services Division of the Arizona Department of Administration,

Defendants.

No. 4:19-cv-00035

PLAINTIFF'S FIRST REQUEST FOR PRODUCTION OF DOCUMENTS AND TANGIBLE THINGS

Pursuant to the Federal Rules of Civil Procedure Rule 26 and 34 (together, the "Rules"), Plaintiff Russell B. Toomey, on behalf of himself and the certified Classes, hereby requests the Defendants produce the following documents and tangible things at the offices of Willkie Farr & Gallagher LLP, 787 Seventh Avenue, New York, New York 10019, within 30 days of service hereof.

DEFINITIONS

1. The term "communication," as used herein, means the transmittal of information (in the form of facts, ideas, inquiries, or otherwise), whether orally or in writing, or by any other means or medium.

2. The terms "concerning," "relating to," "referring to," "arising out of," and their cognates are to be understood in their broadest sense and each means concerning, constituting, identifying, evidencing, summarizing, commenting upon, referring to, relating to, arising out of, describing, digesting, reporting, listing, analyzing, studying, discussing, stating, setting forth, reflecting, interpreting, concerning, recording, including, negating, manifesting, containing or comprising the subject matter identified.

3. The terms "describe" and "description," as used herein, mean to give a detailed written account or representation of the subject matter – including, but not limited to, when used with respect to any act, action, accounting, activity, audit, practice, process, occurrence, occasion, course of conduct, happening, negotiation, relationship, scheme, communication, conference, discussion, development, circumstances, service, transaction, instance, incident, or event – setting forth the following: (a) its general nature; (b) the time and place thereof; (c) a chronological account setting forth each element thereof, what such element consisted of and what transpired as part thereof; (d) the identity (as defined herein) of each person who performed any function or had any role in connection therewith (*i.e.*, speaker, participant, contributor of information, witness, etc.) or who has any knowledge thereof, together with a description of such person's function, role or knowledge; (e) the identity (as defined herein) of each document that refers thereto or that was used, referred to or prepared in the course of or as a result thereof; and (f) the identity (as defined herein) of each oral communication that was a part thereof or referred thereto.

4. The terms "document" and "documents" shall have the broadest meaning allowable under the Rules and applicable case law, and shall include without limitation, electronically stored information and written, printed, typed, recorded, or graphic matter of every kind and description, both originals and copies and all attachments and appendices thereto. Without limiting the foregoing, the terms "document" and "documents" shall include all agreements, contracts, applications, communications, interoffice or intraoffice correspondence, books, letters, telegrams, telexes, messages, memoranda, records, reports, books, summaries, electronic mail, texts, chats, records of telephone conversations or interviews, summaries or other records of personal conversations, minutes or summaries or other records of personal meetings and conferences, summaries or other records of meetings and conferences, summaries, entries, calendars, appointment books, time records, instructions, work assignments, visitor records, forecasts, statistical data, statistical statements, work sheets, drafts, graphs, maps, charts, tables, marginal notations, notebooks, telephone bills or records, bills, statements and records of obligation and expenditure, invoices, lists, journals, advertising, recommendations, files, printouts, compilations, tabulations, purchase orders, receipts, sell orders, confirmations, checks, letters of credit, envelopes or folders or similar containers, vouchers, analyses, studies, surveys, transcripts of hearings, transcripts of testimony, expense reports, microfilm, microfiche, articles, speeches, tape or disc recordings, sound recordings, video recordings, film, tapes, photographs, punch cards, programs, data compilations from which information can be obtained (including matter used in data processing), and other printed, written, handwritten, typewritten, recorded, stenographic, computer-generated, or electronically stored matter (or printouts thereof), however and by whomever produced, prepared, reproduced, disseminated, or made.

5. "Draft(s)" shall mean any formulation, outline, sketch, conceptualization, or version of a document created prior to the final version of that document.

6. The term "factual and/or legal bases" includes, but is not limited to, any and all documents, facts, communications or contentions.

7. The terms "identify," "specify" and "state" mean to refer to the subject matter by providing a detailed account or description of the subject matter, including, but not limited to, the following:

a. when applicable to a document, to set forth in writing at a minimum and in the following order: (i) the name of the document; (ii) the nature of the document (*e.g.*, letter, contract, memorandum) and any other information (*i.e.*, its title, index or file number) which would facilitate in the identification thereof; (iii) the date the document was prepared or created; (iv) the identity of each person who performed any function or had any role in connection therewith (*i.e.*, author, contributor of information, recipient, etc.) or who has any knowledge thereof, together with a description of each such person's function, role or knowledge; (v) its subject matter and substance, or, in lieu thereof, annex a legible copy of the document to Your answers to these interrogatories; (vi) identification of all persons who are in possession of the original and any copy of the document; (vii) its present location and the identity of its present custodian, or, if its present location and custodian are not known, a descript of its last known disposition; (viii) where a document is other than a paper (*i.e.*, computer or recording tape, microfilm disk, microfiche, etc.), a full description of the tangible thing on which the information is recorded, and the device or the devices needed to read or listen to the document; and (ix) if the

document has been destroyed or is otherwise no longer in existence or cannot be found, the reason why such document no longer exists, the identity of the person(s) responsible for document no longer being in existence and the identity of the document's last custodian.

b. when applicable to a natural person, to set forth in writing at a minimum and in the following order: (i) his/her full name; (ii) his/her present and/or last known business and residence address and telephone number, or an undertaking that the person may be contacted through responding counsel; (iii) his/her present or last known business affiliation; and (iv) his/her present or last known business position (including job title and a description of job functions, duties and responsibilities);

c. when applicable to any entity or person other than a natural person, to set forth in writing at a minimum and in the following order: (i) its full name; (ii) the address and telephone number of its principal place of business; (iii) the jurisdiction under the laws of which it has been organized or incorporated and the date of such organization or incorporation; (iv) the identity of all individuals who acted and/or authorized another to act on its behalf in connection with the matters referred to; (v) in the case of a corporation, the names of its directors and principal officers; and (vi) in the case of an entity other than a corporation, the identities of its partners or principals or all individuals who acted or who authorized another to act on its behalf in connection with the matters referred to;

d. when applicable to an oral communication, to set forth in writing at a minimum and in the following order: (i) the date, time, place, manner and substance of such communication; (ii) the identity of all persons who participated in, listened to, or

had access to transcripts or summaries of such communication or copies thereof; (iii) each such person's function, role, or knowledge; and (iv) the identity of all documents which memorialize, commemorate, summarize, record or directly refer or relate, in whole or in part, to such communication.

8. The term "including" means "including, but not limited to," and shall not be construed to limit the scope of any definition or request herein.

9. The term "person" means any natural person, corporation, partnership, proprietorship, association, joint venture, group, governmental or public entity, or any other form or organization of legal entity, and all of their directors, officers, employees, representatives, and agents. The term "person" specifically includes, but is not limited to, any interest or lobbying group, or any employee or representative thereof, such as the Center for Arizona Policy, the Alliance Defending Freedom, the American Legislative Exchange Council, the Christian Medical and Dental Society, and the Franciscan Alliance, Inc.

10. "Defendants" mean Defendants State of Arizona, Arizona Board of Regents, d/b/a University of Arizona, Ron Shoopman, Larry Penley, Ram Krishna, Bill Ridenour, Lyndel Manson, Karrin Taylor Robson, Jay Heiler, Fred DuVal, Andy Tobin, and Paul Shannon and all of their predecessors and successors in interest, and all of their representatives, attorneys, and agents. The Defendant, State of Arizona, includes the current and prior administrations of the Office of the Arizona Governor, the Arizona Attorney General's Office, as well as current and former members and employees of the Arizona Legislature, in their official capacities.

11. The "Plan" means the State of Arizona's self-funded health plan controlled by the Arizona Department of Administration.

12. The "Transgender Healthcare Exclusion" means the policy contained within the Plan to exclude from coverage "gender reassignment surgery," and any and all current or prior iterations of any policy in the Plan that excludes or excluded coverage for any additional medical or surgical treatment or services to treat gender dysphoria ("transition-related care"), including the earliest iteration of the Plan's Transgender Healthcare Exclusion.

13. "You" and "Your" refer to Defendants individually and collectively.

INSTRUCTIONS

1. If You object to any specific request in whole or in part, state with particularity each objection, the basis for it, and the categories of information to which the objection applies. You must respond to any portion of a request to which You do not object.

2. If You fail to produce a document or provide information requested on the grounds that such document or information is no longer in Your possession, custody, or control, You shall state what disposition was made of that document or information, including, when applicable, the circumstances of any loss or destruction of such document or information.

3. Each document requested should be produced in its entirety without deletion or redactions, except as subject to applicable privileges, regardless of whether You consider the entire document to be responsive to these requests or relevant to the claims.

4. You are required to respond to this Request by drawing upon all materials in Your possession, custody, or control. These sources include, but are not limited to, Your employees, successors, assigns, agents, advisors, accountants, experts, representatives, attorneys and/or consultants, or anyone else acting or purporting to act on Your behalf or remote computing system (such as SharePoint or Gmail) with whom You maintain or maintained an account.

5. If any document requested is withheld on the grounds of privilege or otherwise, You shall provide a log with the following information relating to each document or portion of a document withheld:

a. the kind of document (e.g., memorandum, letter, notes, etc.);

b. the date of the document or, if no date appears thereon, the approximate date the document was prepared;

c. the identity of the author(s);

d. the identity of the Person(s) to whom the document is addressed;

e. the identity of any other recipients of the document that appear on the document as having received a copy;

f. the identity of any attachments to the documents and whether the attachments have been produced;

g. the subject matter or the information contained in the document;

h. the nature of the privilege or immunity asserted, including the attorney and client involved, and the grounds for withholding the document; and

i. the number of pages of the document.

If You fail to set forth a sufficient factual basis for the assertion of any claim of privilege or protection, then any arguable claim or privilege or protection shall be waived. Compliance with the above instructions is not to be construed as an admission by Plaintiff that such privilege or protection is valid, and Plaintiff reserves their right to challenge any purported claim of privilege or protection.

6. If You believe that only a portion of a document is protected by an applicable privilege, the non-privileged portion shall be produced with the allegedly privileged portion

redacted and indicated as such. You shall provide the information set forth in Instruction No. 6 for each such redaction. Any attachment to an allegedly privileged document shall be produced unless You also contend that the attachment is privileged, in which case the information required in Instruction No. 6 shall be provided separately for each such attachment.

7. If any documents requested were at one time in existence but no longer are, please so state, specifying in detail for each document: (a) the document type, (b) a specific description of the subject matter of the document, (c) the date upon which the document ceased to exist, (d) the identity of each Person having knowledge of the circumstances under which the document ceased to exist, and (e) the identity of each Person having knowledge or who had knowledge of the contents thereof.

8. Each Request for Production set forth herein is a request for the original (or copy when the original is not available) of the final version of such document(s), as well as non-identical copies by reason of notations or markings.

9. More than one Request for Production set forth herein may call for production of the same document. The presence of such duplication is not intended and shall not be interpreted to narrow or limit in any way the scope of each individual Request for Production set forth herein.

10. The documents or tangible things produced in response hereto shall be segregated and clearly marked or labeled so as to correspond to the specific production request to which such documents or tangible things are responsive and are being produced. Alternatively, such documents or tangible things shall be produced as they are kept in the usual course of business, including the production of files from which such documents or tangible things are taken.

11. Information shall not be withheld merely because such information is stored electronically (e.g., word processing files, electronic mail, databases, accounting information, and spreadsheets).

12. In addition to physical documents or objects, each Request for Production set forth herein specifically calls for the production of electronic or magnetic data responsive to the Request, including data that has been deleted.

13. Each Request for Production set forth herein calls for the following methods of production:

a. *Hard Copy Documents.* (i) All black and white hard copy documents will be scanned and produced in electronic form. The hard copy documents shall be converted to a single page TIFF images and produced following the same protocol set forth herein or otherwise agreed to by the parties. (ii) Images of all file labels, file headings, and file folders associated with any hard copy document will be produced with the images of the hard copy documents. (iii) Document breaks for paper documents shall be based on Logical Document Determination (or "LDD") rather than on physical document breaks. (iv) The database load file shall include the following fields: BEGBATES, ENDBATES, BEGATTACH, ENDATTACH, CUSTODIAN, REDACTED, and CDVOLUME.

b. *Metadata Fields and Processing.* Each of the metadata and coding fields set forth in **Appendix 1** that can be extracted shall be produced for that document. The parties are not obligated to manually populate any of the fields in **Appendix 1** if such fields cannot be extracted from a document, with the exception of the following: BEGBATES, ENDBATES, BEGATTACH, ENDATTACH, and

CUSTODIAN. The parties will make reasonable efforts to ensure that metadata fields automatically extracted from the documents are correct.

c. *TIFFs.* Single page Group IV TIFFs should be provided, at least 300 dots per inch (dpi). Single page TIFF images should be named according to the unique bates number, followed by the extension ".TIF". Original document orientation should be maintained (*i.e.*, portrait to portrait and landscape to landscape).

d. *Text Files.* For each document originating in electronic format, a separate text file containing the full text of each document should be provided with a file with the TIFF images and a file with the document metadata. Text of native files should be extracted directly from the native file. The text file should be named according to the unique bates number, followed by the extension ".TXT." The parties agree that the full text and/or OCR of any document will not be contained within a database load file, but rather as a standalone file with each text file containing the text for an entire single document.

e. *Database Load Files.* An ASCII delimited data file (.txt, .dat, or .csv) that can be loaded into commercially acceptable database software (*e.g.*, Concordance). The first line of each text file must contain a header row identifying each data field by name. Each document within the database load file must contain the same number of fields as identified in the header row.

f. *Cross-Reference Image File Registration.* An image load file that can be loaded into commercially acceptable production software (*e.g.*, Opticon, iPro). Each TIFF in a production must be referenced in the corresponding image load file. An exemplar load file format is below.

ABC0000001,PROD001,\\IMAGES\001\ABC0000001.tif,Y,,,2
ABC0000002,PROD001,\\IMAGES\001\ABC0000002.tif,,,,
ABC0000003,PROD001,\\IMAGES\001\ABC0000003.tif,Y,,,1

g. *Bates Numbering.* All images must be assigned a unique and sequential Bates Number. Each party agrees to use the same Bates Numbering format through its entire production unless a new Bates format is necessary, at which point the party using the new Bates Numbering format will inform the other party of the change.

h. *Protective Order Designations.* Any document(s) determined by the producing party to fall within the scope of a protective order shall have the appropriate level of designated language (*i.e.*, CONFIDENTIAL, ATTORNEYS' EYES ONLY, OUTSIDE COUNSEL RESTRICTED, etc.) afforded by the protective order endorsed on each tiff image of said document(s).

i. *Native File Productions.* The parties agree that when producing a native file, they will include a TIFF image as a placeholder for the file to represent the file in the production set. The TIFF image placeholder for a native file should be branded with a unique Bates number and state "See Native Document" on the TIFF image. The native file should then be renamed to match the Bates number assigned to the document with its original file extension. The filename field produced in the production load file that reflects the original metadata should maintain the original file name. If a native file falls within the scope of a protective order (*see* paragraph (h), above), then the appropriate designation is to be included in the filename along with the assigned Bates number (*i.e.*, ABC000001_CONFIDENTIAL.xls).

j. *Microsoft Office files, WordPerfect, and other standard documents (e.g., Google Docs and PDF documents).* MS Office files, WordPerfect, other standard documents, such as PDF documents, will be converted to single-page TIFF images

and produced consistent with the specifications herein. If the document contains comments or tracked changes, then the TIFF images shall be generated to include the comments or track changes contained in the file.

k. *Email and attachments.* E-mail and attachments should be converted to single-page TIFF images and produced consistent with the specifications provided herein. Attachments shall be processed as separate documents, and the text database load file shall include a field in which the producing party shall identify the production range of all attachments of each e-mail.

l. *Microsoft PowerPoint and other Presentation Files.* The parties shall process presentations (*e.g.*, MS PowerPoint, Google Presently) to include hidden slides and speaker's notes by imaging in a way that both the slide and the speaker's notes display on the TIFF image.

m. *Spreadsheets.* The parties shall produce spreadsheets (*e.g.*, MS Excel, Google Trix) in native format where available. *See paragraph (i) above.* If a spreadsheet requires redaction, the parties will use native file redaction applications (*e.g.*, Blackout).

n. *Good Cause for Additional Native Files.* If good cause exists to request production of specified files in native format, then the party may request such production and provide an explanation of the need for native file review.

o. *Other Documents or Data.* If production of certain structured or other electronic data that is not easily converted to static TIFF images, such as databases, CAD drawings, GIS data, videos, audio files, websites, social media, then the parties will meet and confer to discuss an appropriate form of production.

p. *Social media and other web-based content.* The production of social media or other web-based content should be converted to single-page TIFF images and produced consistent with the specifications provided herein. If the social media and/or web-based content cannot be produced in single-page TIFF images, then the parties shall meet and confer to discuss a form of production. Further, the parties will also confer regarding the specific web location of the social media or other web-based content and agree upon the available metadata that can be produced therewith.

q. *Color Documents.* Parties will produce documents in black and white, unless to do so would alter or obscure the substance of the document. A party may request that a reasonable number of documents be produced in a color format upon review of the other party's production.in single page JPEG format.

r. *Redactions.* In the event that a document requires redaction, the parties agree the native file, if applicable, will be excluded from the production. In addition, any redacted text will be omitted from the full text and/or OCR, and any corresponding metadata fields from the production. The TIFF image will readily identify the redactions.

s. *Production Media.* Documents and electronically stored information ("ESI") shall be produced on optical media (CD or DVD), external hard drives, or via an FTP site, or similar, readily accessible electronic media.

t. *Encryption.* Industry-standard encryption tools and practices must be used when transferring data between parties. Passwords must be at least 8 characters with a mix of character sets and sent in a separate communication from the encrypted data.

Among other places, You shall search for electronic documents stored on all servers, networks, hard drives, desktop computers, notebook computers, personal digital devices, all back-up storage media or devices, and with any third-party cloud providers. Each responsive Document shall be produced in its entirety. In producing documents, if an identical copy appears in more than one Person's files, You shall either (1) produce each copy or (2) provide the names of each Custodian in the "Custodian" field.

14. Documents not otherwise responsive to these requests shall be produced if such documents concern the documents that are responsive to the requests or if such documents are attached to documents called for by these requests and constitute routing slips, transmittal memoranda, letters, emails, comments, evaluations, or similar materials.

15. Your response to these Requests for Production should not be delayed if they cannot be fully complied with by the date set for the presentation of documents for any reason, including, but not limited to, the assertion of any privilege, interposition of any objection, ongoing investigation, or current unavailability of documents. All available documents should be produced on the date set for presentation, and any unavailable documents should be produced as soon as they become available.

16. These Requests for Production are deemed to be continuing in nature so as to require that You supplement Your response if You obtain or discover additional information or documents between the time of the initial response and the time of hearing or trial herein. This paragraph shall not be construed to alter any obligation to comply with all other instructions in these Requests for Production.

17. Plaintiffs hereby expressly reserve the right to supplement these Requests for Production and to propound new requests, to the extent permitted by applicable law and rules.

18. In construing any request, instruction or definition, the singular form of a word shall include the plural and the plural form of a word shall include the singular.

19. The connectives "and" and "or" shall be construed disjunctively or conjunctively as necessary to bring within the scope of the request all documents that might otherwise be construed to be outside of its scope.

20. The terms "all" and "each" shall be construed as all and each, as necessary to bring within the scope of the request all information that might otherwise be construed to be outside of its scope.

21. Plaintiff is willing to meet and confer in good faith with respect to any objections set forth by You.

RELEVANT TIME PERIOD

1. The relevant Time Period for these Requests for Production shall be through the date of production, unless otherwise specified.

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 1: Please produce all documents related to the Plan's current or prior Transgender Healthcare Exclusion, including, but not limited to

(a) all drafts and previous versions of the Transgender Healthcare Exclusion, including the earliest iteration of the Transgender Health Exclusion, and any amendments or supplements thereto (whether actual or proposed);

(b) all documents (to include any formal or informal financial or budgetary or other analyses, actuarial reports, or other reports or memoranda) and communications between Defendants and all internal and external persons (including, but not limited to, any insurance company, any consultant, the Alliance Defending Freedom, the Center for Arizona Policy, or any

lobbying or interest group regarding whether any form of transition-related care or the Transgender Health Exclusion should be adopted, modified, retained, or eliminated, and the rationale provided or discussed.

(c) all documents and communications with internal and external persons pertaining to Defendants' initial decision to exclude transition-related care, as well as any subsequent decisions to adopt, amend, retain, or eliminate any form of transition-related care or the Transgender Health Exclusion, including minutes or recordings of meetings where coverage for or exclusion of any form of transition-related care was discussed.

REQUEST FOR PRODUCTION NO. 2: Please produce all documents and communications between Defendants and internal and external persons relating to and regarding the State of Arizona's decision to join the litigation in the Northern District of Texas bearing Case No. 7:16-cv-00108 (originally filed as *Franciscan Alliance, Inc. et al v. Burwell et al*, later re-designated as *Franciscan Alliance, Inc. et al v. Price et al* and *Franciscan Alliance, Inc. et al v. Azar II et al*), and the State of Arizona's participation in that litigation.

REQUEST FOR PRODUCTION NO. 3: Please produce all versions and iterations of the Plan's policies/lists of Exclusions and General Limitations (*e.g.*, Article 9.1 of ADOA's PPO and EPO Plans, Article 10.1 of ADOA's HSA Plan) from the years 2010 through the present, as well as all documents and communications between Defendants and internal or external persons regarding creating, amending, continuing, or eliminating any exclusion of coverage contained in any version/iteration of the Plan's Exclusions and General Limitations policy, including, but not limited to, the potential costs of enforcing, amending, or eliminating such excluded coverage, the medical necessity, safety, and efficacy (including whether a procedure is deemed experimental or cosmetic) of excluded treatments and services; or the public health effects of enforcing, amending,

or eliminating such excluded coverage. Such documents should include any and all actuarial reports, analyses, or memorandums pertaining to such exclusions of coverage.

REQUEST FOR PRODUCTION NO. 4: Please produce all documents and communications between the Defendants and internal or external persons regarding whether any treatment of gender dysphoria is "Medically Necessary."

REQUEST FOR PRODUCTION NO. 5: Please produce all documents and communications between the Defendants and internal or external persons concerning (a) transgender people, (b) gender transition, (c) change of sex, (d) sex reassignment, (e) transsexualism; or (f) gender reassignment.

REQUEST FOR PRODUCTION NO. 6: Please produce documents sufficient to show, from 2010 to the present:

(a) the number of hysterectomies paid for by the Plan each year, the medical reason for the surgery, and the individual and aggregate cost of the surgeries; and

(b) the number of medically necessary cosmetic or reconstructive surgical procedures paid for by the Plan each year (including but not limited to chest-reconstruction surgery, vaginoplasty, or phalloplasty, or other surgery related to the reproductive or urogenital system) the medical reason for the surgery, and the individual and aggregate cost of the surgeries.

REQUEST FOR PRODUCTION NO. 7: Please produce all documents (to include any formal or informal financial or budgetary or other analyses, plans, actuarial reports, or other reports or memoranda) to show (1) the total annual expenses (*i.e.*, the amounts paid by the Plan to medical providers) for all treatment and services provided under the Plan from 2010 to the present, including a cost breakdown of the total expenses for each type of treatment or service; and (2) the

total annual amounts paid by the Defendants to pay for the Plan for all Plan recipients from 2010 to the present, including an itemized breakdown of the total amounts paid, to the extent possible, and (3) budget projections and actuarial analyses of the Plan's fiscal soundness.

REQUEST FOR PRODUCTION NO. 8: All documents or communications you intend to rely on at trial.

REQUEST FOR PRODUCTION NO. 9: Please produce all documents supporting Your responses to Plaintiff's First Set Of Interrogatories provided to Defendants on June 5, 2020.

DATED this 8th day of December, 2020.

By */s/ Nicholas Reddick*

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CERTIFICATE OF SERVICE

I, Nicholas Reddick, hereby certify that on December 8, 2020 I served the foregoing *Plaintiff's First Request for Production of Documents and Tangible Things* to Defendants via email:

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/s/ Nicholas Reddick

EXHIBIT 3

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Attorneys for Defendants
State of Arizona, Andy Tobin, and Paul Shannon

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,

Plaintiff,

v.

STATE OF ARIZONA; ARIZONA BOARD OF REGENTS D/B/A UNIVERSITY OF ARIZONA, a governmental body of the State of Arizona; RON SHOOPMAN, in his official capacity as Chair of the Arizona Board of Regents; LARRY PENLEY, in his official capacity as Member of the Arizona Board of Regents; RAM KRISHNA, in his official capacity as Secretary of the Arizona Board of Regents; BILL RIDENOUR, in his official capacity as Treasurer of the Arizona Board of Regents; LYNDEL MANSON, in her official capacity as Member of the Arizona Board of Regents; KARRIN TAYLOR ROBSON, in her official capacity as Member of the Arizona Board of Regents; JAY HEILER, in his official capacity as Member of the Arizona Board of Regents; FRED DUVAL, in his official capacity as Member of the Arizona Board of Regents; ANDY TOBIN, in his official capacity as Director of the Arizona

No. 4:19-cv-00035

DEFENDANTS STATE OF ARIZONA'S, ANDY TOBIN'S, AND PAUL SHANNON'S RESPONSES TO PLAINTIFF'S FIRST SET OF INTERROGATORIES

Department of Administration; PAUL SHANNON, in his official capacity as Acting Assistant Director of the Benefits Services Division of the Arizona Department of Administration,

Defendants.

Propounding Party: Russell B. Toomey

Answering Parties: State of Arizona, Andy Tobin, and Paul Shannon

Set No.: One

GENERAL STATEMENT AND OBJECTIONS

1. Defendants object to each interrogatory to the extent that it is vague and/or ambiguous and agrees to respond to Plaintiff's interrogatories based solely on their interpretation of any vague or ambiguous language.

2. Defendants object to each interrogatory to the extent that it is overly broad, unduly burdensome, or oppressive.

3. Defendants object to each interrogatory to the extent that it seeks confidential, proprietary, private, or privileged information and will respond to any such interrogatory, if otherwise discoverable, after the parties have agreed to a protective order.

4. Defendants object to each interrogatory to the extent that it seeks information that is irrelevant to Plaintiff's claims or Defendants' defenses and is not reasonably calculated to lead to the discovery of admissible evidence.

5. Defendants object to each interrogatory to the extent that it requires any action or response beyond that required by the Federal Rules of Civil Procedure, the Scheduling Order, or the Local Rules.

ANSWERS TO INTERROGATORIES

INTERROGATORY NO. 1: Identify and describe all reasons why the State of Arizona's self-funded health plan controlled by the Arizona Department of Administration

(the "Plan") excludes coverage for "[g]ender reassignment surgery" (the "Challenged Exclusion") including, but not limited to, (a) each and every State or governmental interest that you contend is advanced by the exclusion, (b) a detailed explanation for why you contend that the exclusion furthers that state interest, and (c) all facts in support of your explanation.

ANSWER: **The State of Arizona's self-funded health plan excludes coverage for gender reassignment surgery because the State concluded, under the law, that it was not legally required to change its health plan to provide such coverage under either Title VII of the Civil Rights Act or under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. Specifically, prior to the Supreme Court's ruling in *Bostock v. Clayton County*, Title VII protections on the basis of sex had not been applied to individuals based on their sexual orientation or transgender status. Further, rules promulgated by the Department of Health and Human Services ("HHS") regarding nondiscrimination provisions under Section 1557 of the Affordable Care Act prohibited blanket exclusions of all treatments of gender dysphoria, but did not require plans subject to the law to cover all treatments for gender dysphoria or gender transition services. The legal advice that the State received regarding this issue is covered by the attorney-client privilege.**

The State or governmental interests advanced by the exclusion are cost containment and reducing health care costs. The State gathered information from private insurers and public entities who did provide coverage for gender reassignment surgery in an effort to determine how its own health care costs would be impacted. Although the cost estimates varied, they unquestionably showed that removing the exclusion for gender reassignment surgery would increase costs and that such increases could be significant.

INTERROGATORY NO. 2: Identify all persons with knowledge of the reasons

why the Plan excludes coverage for ""[g]ender reassignment surgery," and state what each such person knows.

ANSWER: **Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that Michael T. Liburdi, the former General Counsel for the Office of the Arizona Governor, John M. Fry of the Arizona Attorney General's Office, Nicole A. Ong, the former General Counsel of the ADOA, Christina Corieri, a licensed attorney and Senior Policy Advisor Office of the Arizona Governor, Marie Isaacson, the former Director of the Benefits Services Division of the ADOA, and Scott Bender, the Plan Administrator for the ADOA have knowledge of why the Plan excludes coverage for gender reassignment surgery as described in the response to Interrogatory No. 1 above. ADOA also received attorney-client privileged legal advice from Ryan C. Curtis at Fennemore Craig, P.C., as well as now former Fennemore Craig attorney Erwin Kratz.**

INTERROGATORY NO. 3: Identify all persons with knowledge of the genesis, formulation, adoption, maintenance, or continuation of (a) the Challenged Exclusion and (b) any earlier versions of the exclusion before the current language was adopted, and state what each such person knows.

ANSWER: **Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that Michael T. Liburdi, the former General Counsel for the Office of the Arizona Governor, John M. Fry of the Arizona Attorney General's Office, Nicole A. Ong, the former General Counsel of the ADOA, Christina Corieri, Senior Policy Advisor Office of the Arizona Governor, Marie Isaacson, the former Director of the Benefits Services Division of the ADOA, and Scott Bender, the Plan Administrator for the ADOA have knowledge regarding the Challenged Exclusion.**

ADOA also received attorney-client privileged legal advice from Ryan C. Curtis at Fennemore Craig, P.C., as well as now former Fennemore Craig attorney Erwin Kratz.

INTERROGATORY NO. 4: Identify all persons who participated in formulating, adopting, maintaining, reviewing, approving, or deciding to continue the exclusion of coverage for ""[g]ender reassignment surgery" from the Plan, including any experts consulted, and state what each such person knows.

ANSWER: **Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that Michael T. Liburdi, the former General Counsel for the Office of the Arizona Governor, John M. Fry of the Arizona Attorney General's Office, Nicole A. Ong, the former General Counsel of the ADOA, Christina Corieri, Senior Policy Advisor Office of the Arizona Governor, Marie Isaacson, the former Director of the Benefits Services Division of the ADOA, and Paul Shannon, the Director of the Benefits Services Division of the ADOA participated in these decisions.**

INTERROGATORY NO. 5: Identify all persons who assisted in preparing the answers to these Interrogatories or provided information contained in the answers, and state his or her title, duties, role in preparing the answers, and the interrogatory answer(s) to which he or she provided information or assistance. This identification should also indicate whether the information provided is within his or her knowledge or was obtained from some other person or source; if the information was obtained from another person or source, that person or source should also be identified.

ANSWER: **Defendants object to this interrogatory because it violates the work-product doctrine as set forth in *Hickman v. Taylor*, 329 U.S. 495 (1947). Several courts have held that the work product doctrine covers various aspects of an attorney's investigation, including the witnesses who were interviewed, how long they were**

interviewed, and when they were interviewed. *See, e.g., Commonwealth of Massachusetts v. First Nat'l Supermarkets, Inc.*, 112 F.R.D. 149, 153 (D. Mass. 1986) (holding it was improper to seek disclosure of "the names of persons interviewed by an adverse party's attorney together with the dates and places of such interviews."); *Board of Ed. of Evanston TP v. Admiral Heating*, 104 F.R.D. 23, 32 (N.D. Ill. 1984) (to tell plaintiffs whom defendants have interviewed, where and when such interviews took place, and whether or not a record was made is to give plaintiffs no more knowledge of substantive relevant facts, but rather to afford them the potential for significant insights into the defendant lawyers' preparation of their case and their mental processes); *Besley-Welles Corp. v. Balax, Inc.*, 43 F.R.D. 368, 371 (E.D. Wis. 1968) (interrogatory seeking statement as to adverse party's efforts to locate witnesses goes to attorney's preparation for trial and comes under the *Hickman* rule that gives an attorney's work product qualified immunity from discovery); *Uinta Oil Refining Co. v. Continental Oil Co.*, 226 F. Supp. 495, 506 (D. Utah 1964) (sustaining objection to interrogatory seeking names of all persons from whom plaintiffs had taken or requested statements, explaining that "[t]he detailed pattern of investigation and exploration in and of itself is not a proper subject for discovery.").

INTERROGATORY NO. 6: Identify all public or non-public meetings of Defendants in which the Challenged Exclusion and/or the Plan's coverage for medical or surgical treatments or services to treat gender dysphoria (or "transition-related care") was discussed, listing the date of each meeting, the nature of each meeting, and the attendees of the meeting; and identifying any documents or other materials relating to those meetings in Defendants' custody or control.

ANSWER: **Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that the individuals identified in response to Interrogatory No. 2 who**

were employees of ADOA or the Governor's Office above held meetings and discussions regarding the Plan's surgical treatments or services to treat gender dysphoria between June and November 2016, some of which included the participation of outside counsel from Fennemore Craig, P.C. Defendants possess documents regarding these meetings that will be identified in their privilege log.

INTERROGATORY NO. 7: Identify all research, studies, data, reports, publications, testimony, or other documents considered, reviewed, or relied on by Defendants relating to the Challenged Exclusion, including identifying the date or approximate date of consideration, review, or reliance by the Arizona Board of Regents ("ABOR") and the Arizona Department of Administration (the "ADOA"); and the ADOA and ABOR employee(s) who considered, reviewed, or relied on such documents and their role(s). A complete answer to this interrogatory should include documents relating to the medical necessity, safety, and efficacy (including whether a procedure is deemed experimental) of excluded treatments and services; the public health effects of enforcing, amending, or eliminating the Challenged Exclusion; and the cost/fiscal impact to ADOA or ABOR of enforcing, amending, or eliminating the Challenged Exclusion.

ANSWER: **Defendants considered a Memorandum from Marie Isaacson to Mike Liburdi, General Counsel at the Governor's Office dated August 3, 2016, regarding Affordable Care Act § 1557, and a Memorandum regarding Non-discrimination—Transgender Coverage and a Memorandum from outside legal counsel at Fennemore Craig to Marie Isaacson dated July 20, 2016, regarding Summary and Implications of § 1557 and Transgender Coverage Requirements. Both of these documents are covered by the attorney-client privilege. Defendants also gathered information and data from insurers and other entities regarding their experience providing transgender benefits, including reassignment surgery. Plaintiffs may ascertain the non-privileged information requested in this Interrogatory from the**

documents that Defendants have produced in this action.

INTERROGATORY NO. 8: Identify and describe any formal or informal consideration by Defendants of amending or eliminating the Challenged Exclusion, including identifying the date or approximate date of consideration, the ADOA and ABOR employees or offices involved in such consideration and their role(s), the nature of the considered changes, and what (if any) actions were taken by ADOA and ABOR.

ANSWER: **Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that they have informally considered amending or eliminating the Challenged Exclusion after Plaintiff filed this action and since the Supreme Court's decision in *Bostock v. Clayton County*. Paul Shannon, Scott Bender, and Defendants' counsel have been involved in such considerations.**

DATED this 28th day of September, 2020.

FENNEMORE CRAIG, P.C.

By: *s/ Ryan Curtis*
Timothy J. Berg
Amy Abdo
Ryan Curtis
Shannon Cohan
Attorneys for Defendants State of Arizona, Andy Tobin, and Paul Shannon

CERTIFICATE OF SERVICE

I hereby certify that on this 28th day of September, 2020, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF system for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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16215076

EXHIBIT 4

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Attorneys for Plaintiff Russell B. Toomey

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona; Arizona Board of Regents, d/b/a University of Arizona, a governmental body of the State of Arizona; **Ron Shoopman**, in his official capacity as chair of the Arizona Board Of Regents; **Larry Penley**, in his official capacity as Member of the Arizona Board of Regents; **Ram Krishna**, in his official capacity as Secretary of the Arizona Board of Regents; **Bill Ridenour**, in his official capacity as Treasurer of the Arizona Board of Regents; **Lyndel Manson**, in her official capacity as Member of the Arizona Board of Regents; **Karrin Taylor Robson**, in her official capacity as Member of the Arizona Board of Regents; **Jay Heiler**, in his official capacity as Member of the Arizona Board of Regents; **Fred Duval**, in his official capacity as Member of the Arizona Board of Regents; **Andy Tobin**, in his official capacity as Director of the Arizona Department of Administration; **Paul Shannon**, in his official capacity as Acting Assistant Director of the Benefits Services Division of the Arizona Department of Administration,

Defendants.

4:19-cv-00035-TUC-RM (LCK)

PLAINTIFF'S FIRST SET OF INTERROGATORIES

Pursuant to the Rules of Practice and Procedure of the United States District Court for the District of Arizona Rule 33 and the Federal Rules of Civil Procedure Rule 26 (together, the "Rules"), Plaintiff Russell B. Toomey, by and through counsel undersigned, hereby requests the Defendants answer the following interrogatories (the "Interrogatories," and each an "Interrogatory") in writing and under oath within 14 days of service hereof.

DEFINITIONS

1. The term "communication," as used herein, means the transmittal of information (in the form of facts, ideas, inquiries, or otherwise), whether orally or in writing, or by any other means or medium.

2. The terms "concerning," "relating to," "referring to," "arising out of," and their cognates are to be understood in their broadest sense and each means concerning, constituting, identifying, evidencing, summarizing, commenting upon, referring to, relating to, arising out of, describing, digesting, reporting, listing, analyzing, studying, discussing, stating, setting forth, reflecting, interpreting, concerning, recording, including, negating, manifesting, containing or comprising the subject matter identified.

3. The terms "describe" and "description," as used herein, mean to give a detailed written account or representation of the subject matter – including, but not limited to, when used with respect to any act, action, accounting, activity, audit, practice, process, occurrence, occasion, course of conduct, happening, negotiation, relationship, scheme, communication, conference, discussion, development, circumstances, service, transaction, instance, incident, or event – setting forth the following: (a) its general nature; (b) the time and place thereof; (c) a chronological account setting forth each element thereof, what such element consisted of and what transpired as part thereof; (d) the identity (as defined herein) of each person who performed any function or had any role in connection therewith (*i.e.*, speaker, participant, contributor of information, witness, etc.) or who has any knowledge thereof, together with a description of such person's function, role or knowledge; (e) the identity (as defined herein) of each document that refers thereto or that was used, referred to or prepared in the course of or as a result thereof; and (f) the identity (as defined herein) of each oral communication that was a part thereof or referred thereto.

4. The terms "document" and "documents" shall have the broadest meaning allowable under the Rules and applicable case law, and shall include without limitation, electronically stored information and written, printed, typed, recorded, or graphic matter of every kind and description, both originals and copies and all attachments and appendices thereto.

Without limiting the foregoing, the terms "document" and "documents" shall include all agreements, contracts, applications, communications, interoffice or intraoffice correspondence, books, letters, telegrams, telexes, messages, memoranda, records, reports, books, summaries, electronic mail, texts, chats, records of telephone conversations or interviews, summaries or other records of personal conversations, minutes or summaries or other records of personal meetings and conferences, summaries or other records of meetings and conferences, summaries, entries, calendars, appointment books, time records, instructions, work assignments, visitor records, forecasts, statistical data, statistical statements, work sheets, drafts, graphs, maps, charts, tables, marginal notations, notebooks, telephone bills or records, bills, statements and records of obligation and expenditure, invoices, lists, journals, advertising, recommendations, files, printouts, compilations, tabulations, purchase orders, receipts, sell orders, confirmations, checks, letters of credit, envelopes or folders or similar containers, vouchers, analyses, studies, surveys, transcripts of hearings, transcripts of testimony, expense reports, microfilm, microfiche, articles, speeches, tape or disc recordings, sound recordings, video recordings, film, tapes, photographs, punch cards, programs, data compilations from which information can be obtained (including matter used in data processing), and other printed, written, handwritten, typewritten, recorded, stenographic, computer-generated, or electronically stored matter (or printouts thereof), however and by whomever produced, prepared, reproduced, disseminated, or made.

5. "Draft(s)" shall mean any formulation, outline, sketch, conceptualization, or version of a document created prior to the final version of that document.

6. The term "factual and/or legal bases" includes, but is not limited to, any and all documents, facts, communications or contentions.

7. The terms "identify," "specify" and "state" mean to refer to the subject matter by providing a detailed account or description of the subject matter, including, but not limited to, the following:

a. when applicable to a document, to set forth in writing at a minimum and in the following order: (i) the name of the document; (ii) the nature of the document

(*e.g.*, letter, contract, memorandum) and any other information (*i.e.*, its title, index or file number) which would facilitate in the identification thereof; (iii) the date the document was prepared or created; (iv) the identity of each person who performed any function or had any role in connection therewith (*i.e.*, author, contributor of information, recipient, etc.) or who has any knowledge thereof, together with a description of each such person's function, role or knowledge; (v) its subject matter and substance, or, in lieu thereof, annex a legible copy of the document to Your answers to these interrogatories; (vi) identification of all persons who are in possession of the original and any copy of the document; (vii) its present location and the identity of its present custodian, or, if its present location and custodian are not known, a descript of its last known disposition; (viii) where a document is other than a paper (*i.e.*, computer or recording tape, microfilm disk, microfiche, etc.), a full description of the tangible thing on which the information is recorded, and the device or the devices needed to read or listen to the document; and (ix) if the document has been destroyed or is otherwise no longer in existence or cannot be found, the reason why such document no longer exists, the identity of the person(s) responsible for document no longer being in existence and the identity of the document's last custodian.

b. when applicable to a natural person, to set forth in writing at a minimum and in the following order: (i) his/her full name; (ii) his/her present and/or last known business and residence address and telephone number, or an undertaking that the person may be contacted through responding counsel; (iii) his/her present or last known business affiliation; and (iv) his/her present or last known business position (including job title and a description of job functions, duties and responsibilities);

c. when applicable to any entity or person other than a natural person, to set forth in writing at a minimum and in the following order: (i) its full name; (ii) the address and telephone number of its principal place of business; (iii) the jurisdiction under the laws of which it has been organized or incorporated and the date of such

organization or incorporation; (iv) the identity of all individuals who acted and/or authorized another to act on its behalf in connection with the matters referred to; (v) in the case of a corporation, the names of its directors and principal officers; and (vi) in the case of an entity other than a corporation, the identities of its partners or principals or all individuals who acted or who authorized another to act on its behalf in connection with the matters referred to;

d. when applicable to an oral communication, to set forth in writing at a minimum and in the following order: (i) the date, time, place, manner and substance of such communication; (ii) the identity of all persons who participated in, listened to, or had access to transcripts or summaries of such communication or copies thereof; (iii) each such person's function, role, or knowledge; and (iv) the identity of all documents which memorialize, commemorate, summarize, record or directly refer or relate, in whole or in part, to such communication.

8. The term "including" means "including, but not limited to," and shall not be construed to limit the scope of any definition or request herein.

9. The term "person" means any natural person, corporation, partnership, proprietorship, association, joint venture, group, governmental or public entity, or any other form or organization of legal entity, and all of their directors, officers, employees, representatives, and agents.

10. "Defendants" mean Defendants State of Arizona, Arizona Board of Regents, d/b/a University of Arizona, Ron Shoopman, Larry Penley, Ram Krishna, Bill Ridenour, Lyndel Manson, Karrin Taylor Robson, Jay Heiler, Fred DuVal, Andy Tobin, and Paul Shannon and all of their predecessors and successors in interest, and all of their representatives, attorneys, and agents.

11. "You" and "Your" refer to Defendants individually and collectively.

INSTRUCTIONS

1. If You object to any of the Interrogatories in whole or in part, state with particularity each objection, the basis for it, and the categories of information to which the objection applies. You must respond to any portion of the Interrogatory to which You do not object.

2. Each interrogatory shall be answered separately, and Your answer shall set forth verbatim the interrogatory to which it is in response. The answer to an interrogatory shall not be supplied by referring to the answer to another interrogatory unless the answer to the interrogatory being referred to supplies a complete and accurate answer to the interrogatory being answered.

3. You are required to answer each interrogatory set forth below, regardless of whether the information is possessed by You or by any successors, assigns, agents, accountants, experts, representatives, attorneys and/or consultants or anyone else acting or purporting to act on Your behalf.

4. If You withhold any information or decline to fully identify any person, document or communication in response to any of the interrogatories set forth below on grounds of privilege or pursuant to the work product doctrine, provide the basis for Your claim of privilege or attorney work product and answer the interrogatory to the extent You do not claim a privilege.

5. The interrogatories set forth below shall be deemed to be continuing in nature in accordance with Rule 26 so as to require supplementation in the event that You obtain or become aware of any additional information responsive to these interrogatories.

6. In construing any interrogatory, instruction or definition, the singular form of a word shall include the plural and the plural form of a word shall include the singular.

7. The connectives "and" and "or" shall be construed disjunctively or conjunctively as necessary to bring within the scope of the request all documents that might otherwise be construed to be outside of its scope.

8. The terms "all" and "each" shall be construed as all and each, as necessary to bring within the scope of the request all information that might otherwise be construed to be outside

of its scope.

RELEVANT TIME PERIOD

The relevant Time Period for these Requests shall be through the date in which the interrogatories are answered, unless otherwise specified.

INTERROGATORIES

INTERROGATORY NO. 1: Identify and describe all reasons why the State of Arizona's self-funded health plan controlled by the Arizona Department of Administration (the "Plan") excludes coverage for "[g]ender reassignment surgery" (the "Challenged Exclusion") including, but not limited to, (a) each and every State or governmental interest that you contend is advanced by the exclusion, (b) a detailed explanation for why you contend that the exclusion furthers that state interest, and (c) all facts in support of your explanation.

INTERROGATORY NO. 2: Identify all persons with knowledge of the reasons why the Plan excludes coverage for ""[g]ender reassignment surgery," and state what each such person knows.

INTERROGATORY NO. 3: Identify all persons with knowledge of the genesis, formulation, adoption, maintenance, or continuation of (a) the Challenged Exclusion and (b) any earlier versions of the exclusion before the current language was adopted, and state what each such person knows.

INTERROGATORY NO. 4: Identify all persons who participated in formulating, adopting, maintaining, reviewing, approving, or deciding to continue the exclusion of coverage for ""[g]ender reassignment surgery" from the Plan, including any experts consulted, and state what each such person knows.

INTERROGATORY NO. 5: Identify all persons who assisted in preparing the answers to these Interrogatories or provided information contained in the answers, and state his or her title, duties, role in preparing the answers, and the interrogatory answer(s) to which he or she provided information or assistance. This identification should also indicate whether the information provided is within his or her knowledge or was obtained from some other person or source; if the information was obtained from another person or source, that person or source

should also be identified.

INTERROGATORY NO. 6: Identify all public or non-public meetings of Defendants in which the Challenged Exclusion and/or the Plan's coverage for medical or surgical treatments or services to treat gender dysphoria (or "transition-related care") was discussed, listing the date of each meeting, the nature of each meeting, and the attendees of the meeting; and identifying any documents or other materials relating to those meetings in Defendants' custody or control.

INTERROGATORY NO. 7: Identify all research, studies, data, reports, publications, testimony, or other documents considered, reviewed, or relied on by Defendants relating to the Challenged Exclusion, including identifying the date or approximate date of consideration, review, or reliance by the Arizona Board of Regents ("ABOR") and the Arizona Department of Administration (the "ADOA"); and the ADOA and ABOR employee(s) who considered, reviewed, or relied on such documents and their role(s). A complete answer to this interrogatory should include documents relating to the medical necessity, safety, and efficacy (including whether a procedure is deemed experimental) of excluded treatments and services; the public health effects of enforcing, amending, or eliminating the Challenged Exclusion; and the cost/fiscal impact to ADOA or ABOR of enforcing, amending, or eliminating the Challenged Exclusion.

INTERROGATORY NO. 8: Identify and describe any formal or informal consideration by Defendants of amending or eliminating the Challenged Exclusion, including identifying the date or approximate date of consideration, the ADOA and ABOR employees or offices involved in such consideration and their role(s), the nature of the considered changes, and what (if any) actions were taken by ADOA and ABOR.

DATED this 5th day of June, 2020.

ACLU FOUNDATION OF ARIZONA

By */s/ Christine K. Wee*
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Attorneys for Plaintiff Russell B. Toomey

CERTIFICATE OF SERVICE

I, Christine K. Wee, hereby certify that on June 5, 2020 I served the foregoing *Plaintiff's First Set of Interrogatories* to Defendants via email:

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/s/ Christine K. Wee

EXHIBIT 5

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Attorneys for Defendants
State of Arizona, Andy Tobin, and Paul Shannon

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona; Arizona Board of Regents d/b/a University of Arizona, a governmental body of the State of Arizona; Ron Shoopman, in his official capacity as Chair of the Arizona Board of Regents; Larry Penley, in his official capacity as Member of the Arizona Board of Regents; Ram Krishna, in his official capacity as Secretary of the Arizona Board of Regents; Bill Ridenour, in his official capacity as Treasurer of the Arizona Board of Regents; Lyndel Manson, in her official capacity as Member of the Arizona Board of Regents; Karrin Taylor Robson, in her official capacity as Member of the Arizona Board of Regents; Jay Heiler, in his official capacity as Member of the Arizona Board of Regents; Fred Duval, in his official capacity as Member of the Arizona Board of Regents; Andy Tobin, in his official capacity as Director of the Arizona Department of Administration; Paul

No. 4:19-cv-00035

DEFENDANTS STATE OF ARIZONA'S, ANDY TOBIN'S, AND PAUL SHANNON'S FIRST SUPPLEMENTAL RESPONSES TO PLAINTIFF'S FIRST SET OF INTERROGATORIES

Shannon, in his official capacity as Acting Assistant Director of the Benefits Services Division of the Arizona Department of Administration,

Defendants.

Propounding Party: Russell B. Toomey

Answering Parties: State of Arizona, Andy Tobin, and Paul Shannon

Set No.: One

GENERAL STATEMENT AND OBJECTIONS

1. Defendants object to each interrogatory to the extent that it is vague and/or ambiguous and agrees to respond to Plaintiff's interrogatories based solely on their interpretation of any vague or ambiguous language.

2. Defendants object to each interrogatory to the extent that it is overly broad, unduly burdensome, or oppressive.

3. Defendants object to each interrogatory to the extent that it seeks confidential, proprietary, private, or privileged information and will respond to any such interrogatory, if otherwise discoverable, after the parties have agreed to a protective order.

4. Defendants object to each interrogatory to the extent that it seeks information that is irrelevant to Plaintiff's claims or Defendants' defenses and is not reasonably calculated to lead to the discovery of admissible evidence.

5. Defendants object to each interrogatory to the extent that it requires any action or response beyond that required by the Federal Rules of Civil Procedure, the Scheduling Order, or the Local Rules.

ANSWERS TO INTERROGATORIES

INTERROGATORY NO. 1: Identify and describe all reasons why the State of Arizona's self-funded health plan controlled by the Arizona Department of Administration (the "Plan") excludes coverage for "[g]ender reassignment surgery" (the "Challenged

Exclusion") including, but not limited to, (a) each and every State or governmental interest that you contend is advanced by the exclusion, (b) a detailed explanation for why you contend that the exclusion furthers that state interest, and (c) all facts in support of your explanation.

ANSWER: The State of Arizona's self-funded health plan excludes coverage for gender reassignment surgery because the State concluded, under the law, that it was not legally required to change its health plan to provide such coverage under either Title VII of the Civil Rights Act or under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. Specifically, prior to the Supreme Court's ruling in *Bostock v. Clayton County*, Title VII protections on the basis of sex had not been applied to individuals based on their sexual orientation or transgender status. Further, rules promulgated by the Department of Health and Human Services ("HHS") regarding nondiscrimination provisions under Section 1557 of the Affordable Care Act prohibited blanket exclusions of all treatments of gender dysphoria, but did not require plans subject to the law to cover all treatments for gender dysphoria or gender transition services. The legal advice that the State received regarding this issue is covered by the attorney-client privilege.

The State or governmental interests advanced by the exclusion are cost containment and reducing health care costs. The State gathered information from private insurers and public entities who did provide coverage for gender reassignment surgery in an effort to determine how its own health care costs would be impacted. Although the cost estimates varied, they unquestionably showed that removing the exclusion for gender reassignment surgery would increase costs and that such increases could be significant.

FIRST SUPPLEMENTAL ANSWER: At some point prior to 2005, the State of Arizona moved its healthcare coverage for employees to a self-funded health plan. At that time, the State maintained the same plan documents, including the same exclusions, as was

utilized by the prior insurance providers. The plan documents included an exclusion for "transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery."

INTERROGATORY NO. 2: Identify all persons with knowledge of the reasons why the Plan excludes coverage for ""[g]ender reassignment surgery," and state what each such person knows.

ANSWER: Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that Michael T. Liburdi, the former General Counsel for the Office of the Arizona Governor, John M. Fry of the Arizona Attorney General's Office, Nicole A. Ong, the former General Counsel of the ADOA, Christina Corieri, a licensed attorney and Senior Policy Advisor Office of the Arizona Governor, Marie Isaacson, the former Director of the Benefits Services Division of the ADOA, and Scott Bender, the Plan Administrator for the ADOA have knowledge of why the Plan excludes coverage for gender reassignment surgery as described in the response to Interrogatory No. 1 above. ADOA also received attorney-client privileged legal advice from Ryan C. Curtis at Fennemore Craig, P.C., as well as now former Fennemore Craig attorney Erwin Kratz.

INTERROGATORY NO. 3: Identify all persons with knowledge of the genesis, formulation, adoption, maintenance, or continuation of (a) the Challenged Exclusion and (b) any earlier versions of the exclusion before the current language was adopted, and state what each such person knows.

ANSWER: Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that Michael T. Liburdi, the former General Counsel for the Office of the Arizona Governor, John M. Fry of the Arizona Attorney General's Office, Nicole A. Ong, the former General Counsel of the ADOA, Christina Corieri, Senior Policy Advisor Office

of the Arizona Governor, Marie Isaacson, the former Director of the Benefits Services Division of the ADOA, and Scott Bender, the Plan Administrator for the ADOA have knowledge regarding the Challenged Exclusion. ADOA also received attorney-client privileged legal advice from Ryan C. Curtis at Fennemore Craig, P.C., as well as now former Fennemore Craig attorney Erwin Kratz.

INTERROGATORY NO. 4: Identify all persons who participated in formulating, adopting, maintaining, reviewing, approving, or deciding to continue the exclusion of coverage for ""[g]ender reassignment surgery" from the Plan, including any experts consulted, and state what each such person knows.

ANSWER: Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that Michael T. Liburdi, the former General Counsel for the Office of the Arizona Governor, John M. Fry of the Arizona Attorney General's Office, Nicole A. Ong, the former General Counsel of the ADOA, Christina Corieri, Senior Policy Advisor Office of the Arizona Governor, Marie Isaacson, the former Director of the Benefits Services Division of the ADOA, and Paul Shannon, the Director of the Benefits Services Division of the ADOA participated in these decisions.

INTERROGATORY NO. 5: Identify all persons who assisted in preparing the answers to these Interrogatories or provided information contained in the answers, and state his or her title, duties, role in preparing the answers, and the interrogatory answer(s) to which he or she provided information or assistance. This identification should also indicate whether the information provided is within his or her knowledge or was obtained from some other person or source; if the information was obtained from another person or source, that person or source should also be identified.

ANSWER: Defendants object to this interrogatory because it violates the work-product doctrine as set forth in *Hickman v. Taylor*, 329 U.S. 495 (1947). Several courts

have held that the work product doctrine covers various aspects of an attorney's investigation, including the witnesses who were interviewed, how long they were interviewed, and when they were interviewed. *See, e.g., Commonwealth of Massachusetts v. First Nat'l Supermarkets, Inc.*, 112 F.R.D. 149, 153 (D. Mass. 1986) (holding it was improper to seek disclosure of "the names of persons interviewed by an adverse party's attorney together with the dates and places of such interviews."); *Board of Ed. of Evanston TP v. Admiral Heating*, 104 F.R.D. 23, 32 (N.D. Ill. 1984) (to tell plaintiffs whom defendants have interviewed, where and when such interviews took place, and whether or not a record was made is to give plaintiffs no more knowledge of substantive relevant facts, but rather to afford them the potential for significant insights into the defendant lawyers' preparation of their case and their mental processes); *Besley-Welles Corp. v. Balax, Inc.*, 43 F.R.D. 368, 371 (E.D. Wis. 1968) (interrogatory seeking statement as to adverse party's efforts to locate witnesses goes to attorney's preparation for trial and comes under the *Hickman* rule that gives an attorney's work product qualified immunity from discovery); *Uinta Oil Refining Co. v. Continental Oil Co.*, 226 F. Supp. 495, 506 (D. Utah 1964) (sustaining objection to interrogatory seeking names of all persons from whom plaintiffs had taken or requested statements, explaining that "[t]he detailed pattern of investigation and exploration in and of itself is not a proper subject for discovery.").

INTERROGATORY NO. 6: Identify all public or non-public meetings of Defendants in which the Challenged Exclusion and/or the Plan's coverage for medical or surgical treatments or services to treat gender dysphoria (or "transition-related care") was discussed, listing the date of each meeting, the nature of each meeting, and the attendees of the meeting; and identifying any documents or other materials relating to those meetings in Defendants' custody or control.

ANSWER: Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection,

Defendants state that the individuals identified in response to Interrogatory No. 2 who were employees of ADOA or the Governor's Office above held meetings and discussions regarding the Plan's surgical treatments or services to treat gender dysphoria between June and November 2016, some of which included the participation of outside counsel from Fennemore Craig, P.C. Defendants possess documents regarding these meetings that will be identified in their privilege log.

FIRST SUPPLEMENTAL ANSWER: No meetings were held regarding the prior iteration of the exclusion for gender reassignment surgery. The exclusion was adopted when the State of Arizona transferred its healthcare coverage to a self-funded health plan. However, at that time, the State merely continued the coverages and exclusions utilized by its prior insurance providers. No known meetings were held to discuss the transgender care exclusion until the issuance of Patient Protection and Affordable Care Act ("ACA") Rule 1557.

INTERROGATORY NO. 7: Identify all research, studies, data, reports, publications, testimony, or other documents considered, reviewed, or relied on by Defendants relating to the Challenged Exclusion, including identifying the date or approximate date of consideration, review, or reliance by the Arizona Board of Regents ("ABOR") and the Arizona Department of Administration (the "ADOA"); and the ADOA and ABOR employee(s) who considered, reviewed, or relied on such documents and their role(s). A complete answer to this interrogatory should include documents relating to the medical necessity, safety, and efficacy (including whether a procedure is deemed experimental) of excluded treatments and services; the public health effects of enforcing, amending, or eliminating the Challenged Exclusion; and the cost/fiscal impact to ADOA or ABOR of enforcing, amending, or eliminating the Challenged Exclusion.

ANSWER: Defendants considered a Memorandum from Marie Isaacson to Mike Liburdi, General Counsel at the Governor's Office dated August 3, 2016 regarding

Affordable Care Act § 1557, and a Memorandum regarding Non-discrimination—Transgender Coverage and a Memorandum from outside legal counsel at Fennemore Craig to Marie Isaacson dated July 20, 2016 regarding Summary and Implications of § 1557 and Transgender Coverage Requirements. Both of these documents are covered by the attorney-client privilege. Defendants also gathered information and data from insurers and other entities regarding their experience providing transgender benefits, including reassignment surgery. Plaintiffs may ascertain the non-privileged information requested in this Interrogatory from the documents that Defendants have produced in this action.

FIRST SUPPLEMENTAL ANSWER: When the State of Arizona transferred its healthcare coverage to a self-funded health plan, it adopted the coverages and exclusions utilized by its prior insurance providers, which included the prior iteration of the exclusion for gender reassignment surgery. No known additional documents were reviewed in relation to the transgender care exclusion until the issuance of ACA Rule 1557.

INTERROGATORY NO. 8: Identify and describe any formal or informal consideration by Defendants of amending or eliminating the Challenged Exclusion, including identifying the date or approximate date of consideration, the ADOA and ABOR employees or offices involved in such consideration and their role(s), the nature of the considered changes, and what (if any) actions were taken by ADOA and ABOR.

ANSWER: Defendants object to this interrogatory because it seeks information covered by the attorney-client privilege. Subject to and without waiving this objection, Defendants state that they have informally considered amending or eliminating the Challenged Exclusion after Plaintiff filed this action and since the Supreme Court's decision in *Bostock v. Clayton County*. Paul Shannon, Scott Bender, and Defendants' counsel have

. . .

. . .

. . .

been involved in such considerations.

DATED this 21st day of January, 2021.

FENNEMORE CRAIG, P.C.

By: *s/ Ryan Curtis*
Timothy J. Berg
Amy Abdo
Ryan Curtis
Shannon Cohan
Attorneys for Defendants State of Arizona, Andy Tobin, and Paul Shannon

COPY of the foregoing e-mailed this 21st day of January, 2021 to:

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s/ Ryan Curtis

17734350

EXHIBIT 6

In The Matter Of:

Toomey vs.

State of AZ

Marie Frances Isaacson

March 26, 2021

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IN THE UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,

Plaintiff,

vs. 4:19-cv-00035

STATE OF ARIZONA; ARIZONA BOARD OF REGENTS, D/B/A UNIVERSITY OF ARIZONA, a governmental body of the State of Arizona; et al.,

Defendants.

VIDEOTAPED DEPOSITION OF MARIE FRANCES ISAACSON

Via Zoom videoconference
March 26, 2021
8:21 a.m.

Glennie Reporting Services, LLC
1555 East Orangewood Avenue
Phoenix, Arizona 85020

602.266.6535
www.glennie-reporting.com

Prepared by:

Jill Marnell, RPR
Arizona Certified
Reporter No. 50021

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INSTRUCTIONS TO THE WITNESS NOT TO ANSWER

VIDEOTAPED DEPOSITION OF MARIE FRANCES ISAACSON

The deposition of MARIE FRANCES ISAACSON was taken on March 26, 2021, commencing at 8:21 a.m., via Zoom videoconference, before JILL MARNELL, a Certified Reporter, Certificate No. 50021, for the State of Arizona.

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Also present were:

Michael Noonan, videographer

Kim Suciu

Stephanie Rosenberg, via videoconference

THE VIDEOGRAPHER: We are on the record. Today's date is March 26, 2021. The time on the video monitor is 8:21 a.m. Here begins Video Number 1 in the deposition of Marie Isaacson in the matter of Russell B. Toomey versus State of Arizona, et al., in the United States District Court District of Arizona, Case Number 4:19-CV-00035.

The court reporter is Jill Marnell, representing Glennie Reporting Services, 1555 East Orangewood Avenue, Phoenix, Arizona 85020. My name is Michael Noonan. I'm the certified legal video specialist in association with Forensic Video Deposition Services, 11111 North Scottsdale Road, Suite 205, Scottsdale, Arizona 85254.

This deposition is taking place at the law offices of Fennemore Craig, PC, 2394 East Camelback Road, Suite 600, Phoenix, Arizona, 85016.

Counsel will now state their appearance and everyone else appearing remotely for their appearance and affiliations and anyone else attending remotely, beginning with the plaintiff, please.

MR. WALL: Good morning. This is Jordan Wall of Willkie Farr & Gallagher. I am joined in the room by my colleagues Victoria Sheets and Justin Garbacz. I'm also joined by my colleague telephonically Brandon Villa.

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some of the emails with Fennemore Craig I know it was around 2016 or 2015 -- I can't remember the -- all the emails -- that there was a question regarding our plan and what we covered with -- what we did and didn't cover with respect to gender dysphoria.

Q. When you first became aware of the issue -- And I think it was in 2015. We'll go through the exhibits you looked at and maybe some others -- what was ADOA's -- what did ADOA's plan cover by way of coverage for gender dysphoria?

A. I know we looked at the plan document, but I think it didn't cover -- It didn't cover anything, I don't think.

Q. And I think that's right.

And at some point the plan was changed to cover some services for people with gender dysphoria; correct?

A. Correct.

Q. And was that done before you got involved in the issue or after?

A. I'm sorry. I'm not sure I understand what you are saying.

Q. There -- there's a health plan offered by the Arizona Department of Administration; correct?

A. Yes.

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Q. Let's call that the plan. Did the plan provide for any services for gender dysphoria before 2015?

A. Not to my knowledge.

Q. Okay. And so you were in charge of the benefits under the plan when some services for gender dysphoria were added to the plan.

A. Yes.

Q. Who else was -- Were you involved in that decision?

A. Yes.

Q. Did you make it, in effect?

A. No.

Q. Who made it?

A. It was in consultation with our attorneys and the governor's office and the director's office.

Q. Did you recommend that those services be covered?

A. No.

Q. Do you know --

A. I didn't --

Q. Go ahead. I'm sorry.

A. We sought legal counsel regarding what was required.

Q. So you were looking at it in terms of what was required, not in any other sense; correct?

A. Correct.

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Q. And am I correct in assuming that if it wasn't required the Arizona Department of Administration and others making the decision weren't going to implement those other services?

A. I don't know that to be true. I don't know.

Q. Did you determine that it was required to add the services that were added in 2015?

A. We sought legal counsel and that -- with the legal counsel's recommendation and meeting with the governor's office there was a decision made -- a conclusion made to cover some services.

Q. What services were covered and what services were not covered?

A. The counseling and hormone therapy were covered. And surgery was not covered.

Q. Was there an explanation given as to why surgery was not covered?

A. The -- the discussion -- the discussion was that the requirement was that some services are going -- are required to be covered, and the services that we are going to cover are hormone therapy and counseling.

Q. Was it determined by anyone that surgery was not required to be covered?

A. Yes.

Q. And who determined that? Your counsel?

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A. I was --

MR. CURTIS: Objection.

THE COURT REPORTER: I'm sorry, who was that?

MR. CURTIS: That's Ryan Curtis objecting to the form of the question --

THE COURT REPORTER: Thank you.

MR. CURTIS: -- and advising Ms. Isaacson not to speak to direct legal counsel received.

Q. BY MR. ECKSTEIN: Did anyone other than counsel determine that surgery for gender dysphoria was not required by the law?

A. I would say it was a combination of legal counsel and the governor's office and the director's office and the Attorney General's Office.

Q. Did you make that determination yourself?

A. No.

Q. It appears from the documents that I have seen that your involvement in this issue occurred as early as September 2015. And let's just take a look at Tab 32. Do you have the witness book in front of you?

MR. CURTIS: We will need a minute because we have not opened those until directed --

MR. ECKSTEIN: Okay.

MR. CURTIS: -- so I'm going to open those

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and pass them to her.
MR. YOST: (Sotto voce.)
MR. ECKSTEIN: I'm sorry?
MR. YOST: (Sotto voce.)
MR. ECKSTEIN: Oh, yeah, let's put it up on the screen.
MR. WALL: Will you be showing these on the screen, Paul?
MR. ECKSTEIN: Yes, we will. Tab 32.
THE COURT REPORTER: Are we going to mark this?
MR. ECKSTEIN: I'm going to mark it. Tab 32. I understand what's happening in this case is we start with Exhibit 1 in each deposition. That's what the plaintiff has done; is that correct, Jordan?
MR. WALL: That's correct. And just to clarify, we will -- we have premarked our exhibits and submitted them -- transmitted them physically to all the parties and we'll be using the numbering based on that premarking.
MR. ECKSTEIN: So --
MR. WALL: So if you want to do a separate system that's fine, but --
MR. ECKSTEIN: What number do you start with? 1?

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MR. WALL: That's correct.
MR. ECKSTEIN: And what number do you end with?
MR. WALL: At the moment we end with 65. Although we transmitted two exhibits this morning that we expect to use, to go through 67.
MR. ECKSTEIN: So if I start with Exhibit 100 do you think that's safe?
MR. WALL: That should be fine.
MR. ECKSTEIN: Okay. So let's mark Tab 32 as Exhibit 100 in the deposition of Marie Isaacson.
Q. BY MR. ECKSTEIN: You see it on the screen, Marie?
A. I do.
Q. And the bottom email is by you to a Chris Giammona -- Oh, I'm sorry, that's not the bottom one. If you turn the page -- if we could turn the page and look at the very last email in the email string you will see an email from you to Chanelle Bergren dated September 25, 2015.
A. Yes, I see that.
Q. And in it you write, quote, the claim will be that the plan is discriminatory, period. What would be our response? Is this standard to exclude?
You wrote that?

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A. Yes.
Q. And who is Chanelle Bergren?
A. She was the plan administration manager.
Q. Did she answer you?
A. Yes.
Q. And what did she say?
A. Do you want me to read the response?
Q. Yeah. Or if she said anything in addition to that, let me know.
A. [As read]: Mercer confirmed there are no current laws which require a plan to cover a -- to cover transgender benefits. As a result, the plan is not discriminating when excluding benefit coverage. The majority of their clients do not offer transgender coverage. The State of California, State of Oregon, State of Colorado, State of Washington, and the University of California do offer transgender benefits. I have provided links to applicable information below.
Q. Why did you ask that question of Chanelle?
A. Based on the subject line, it looks like I got a question from the University of Arizona.
Q. Had you been talking to the University of Arizona about covering surgery for gender dysphoria?
A. Yes.
Q. Do you recall with whom you were talking?

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A. Helena -- I can't remember her last name. Maybe Rodrigues.
Q. Just one person?
A. There was somebody that worked with her, Staci. I can't remember Staci's last name. And there was a -- there was an additional person that I -- that I remember from reviewing the email strings with Ryan Curtis.
Q. You knew from your discussions with the folks at the University of Arizona that the university was interested in having ADOA's plan provide better healthcare coverage for transgender people; correct?
A. Yes.
Q. And they were pushing for basic benefits before they were implemented; correct?
A. Yes.
Q. And they also were pushing for benefits to cover transgender gender dysphoria surgery; correct?
A. I think so.
Q. Well, didn't you have a number of meetings with people at the University of Arizona where they pointed out that professors and other staff at the University of Arizona were interested in having that coverage?
A. I wouldn't say -- Well, phone conversations. There were a number of phone conversations.
Q. Oh, okay. And let's include phone conversations

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with face-to-face conversations. There were a number of those; correct?
A. Yes.
Q. And they made clear that they wanted coverage for surgery for gender dysphoria; correct?
A. Yes.
Q. And ultimately, at least while you were at ADOA, that was not provided; correct?
A. Yes.
Q. Did the University of Arizona folks you talked with tell you why they wanted to have the coverage for surgery for gender dysphoria for their professors and staff?
A. Helena said that there was a meeting with the U of A president and that there was concern because there -- transgender studies was offered at the University of Arizona and there were concerns that our health plan didn't cover transgender reassignment surgery, didn't cover it -- didn't cover that at all, and that -- In particular I remember that there were professors with children and they were paying for treatment out of pocket and it was very expensive.
Q. So they made it clear that it was an important issue.
A. Yes.

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Q. And what did you say in response to those conversations?
A. Currently not covered by our plan.
Q. Did you tell them ADOA was exploring the possibility of covering surgery for gender dysphoria?
A. I said we were researching it.
Q. And did you research it?
A. Yes.
Q. And I think the research took place around this time, starting in September of 2015 and went through -- at least through November of 2015. We can look at the documents, and will, as time allows.
What did the research tell you about coverage for gender dysphoria surgery?
A. I think the majority of our plans said that it was not covered and, you know, confirmation that some states did cover it.
Q. So were you looking to see whether other states covered it to determine whether the ADOA should cover it?
A. I was researching what -- what existed as far as in the benefits world, reached out to Mercer, reached out to all of our health plans, trying to gather as much information as possible about it to help inform a decision.
Q. Well, one of the things that the ADOA health plan

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covered was gender dysphoria surgery for students at this time; isn't that correct?
A. Not to my knowledge.
Q. You have no knowledge of whether surgery for gender dysphoria was covered by any ADOA plan for students at any of the universities?
A. Not to my knowledge.
Q. Okay. Would that surprise you if that was the case?
A. Yes.
Q. Why?
A. Because you're talking about the ADOA benefit plan. You called it the plan.
Q. Yes. What was --
A. And there was --
Q. Go ahead --
A. There was --
Q. -- I'm sorry.
A. There was a disallowance in the plan description that said it was not covered, it was not a covered service.
Q. That's for staff and -- and for -- and for professors. We're talking about students now. And were the students on the same plan?
A. The DOA benefit -- Oh, students. I'm sorry, I

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was thinking of children. No, the students were not covered by the DOA health plan.
Q. Okay.
A. I was thinking of employees and their children.
Q. Okay. Let's go back. Students are children, too. And maybe some of them are children of faculty. But if a student --
There is a plan that provides health insurance benefits for students; correct?
A. Not through -- not through DOA.
Q. Okay. Do you know who offers that?
A. I am not aware of it.
Q. Okay. So again, would it surprise you that students actually had cover -- coverage for gender dysphoria surgery?
A. You're not speaking under the DOA plan, you're just saying in general?
Q. In general, yeah.
A. I really didn't give it any thought.
Q. At the time you left ADOA the plan offered insurance from four providers; correct? Four insurance companies?
A. Yes.
Q. And do you remember the names of those companies?
A. Yes.

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Q. Could you tell us what they are?
A. Aetna, Cigna, Blue Cross Blue Shield of Arizona, and UnitedHealthcare.
Q. Did any of those companies offer surgery -- surgery for gender dysphoria, on any of their commercial plans or any plans at all?
A. You know, I know we received the emails, but I don't remember what the response was.
Q. You don't remember whether you could have asked Aetna, for example, whether they covered gender dysphoria surgery and what answer they gave you?
A. I remember asking the question of all four plans. I don't remember which -- what plan responded with what answer.
Q. Okay. But you do remember that some of the plans told you, yes, and we do cover gender dysphoria surgery?
A. My biggest recollection is that it was not covered, the majority of the response was it was not covered.
Q. Majority. So that -- Was there a minority that did cover it?
A. I think so. I --
Q. Okay. Well, we can -- we can look at exhibits to ferret that out.
Do you recall any states offering surgery

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for gender -- gender dysphoria under their State plans?
A. Well, just based on the email from Chanelle that we just looked at, those states do offer transgender benefits. But I guess based on this I don't know whether it's surgery or what the benefits are.
Q. Okay. Was one of the issues in determining whether the plan offered by the Arizona Department of Administration for employees of the State of Arizona, which included the faculty and staff at -- at the universities, based on the cost of that benefit?
A. I would say that in researching it that was one of the items that we did research, was the cost of the benefit.
Q. And you determined that the cost was de minimis, didn't you?
A. As I recall there was a range of costs.
Q. And based on additions to premiums for those who participated in the plan, what was the range? Cents per premium.
A. I -- I know we just reviewed that last Sunday, but I can't -- I don't remember what the range was.
Q. Well, it was as low as three cents. Do you recall that?
A. I don't recall.
Q. Okay. But you recall that all the additions were

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under a dollar per plan.
A. I --
MR. CURTIS: Objection.
MR. ECKSTEIN: Per employee. Per employee per plan.
THE WITNESS: I -- I -- I don't remember, Paul.
Q. BY MR. ECKSTEIN: Okay. Well, we'll -- we'll take a look.
Thinking back, did you believe that the -- the cost that was estimated was -- was too high to justify providing that benefit?
A. I don't remember that being -- We discussed cost, but I don't remember that being the driving factor in the discussion.
Q. What was the deciding factor?
A. What was required by law. What was required by law for us to cover.
Q. So as you recall it, if the -- Strike that.
As you recall it, the persons making the decisions were focused on what was legally required. And if it wasn't legally required, surgery for gender dysphoria was not going to be offered in the plan.
A. What I recall is that there was a decision that had to be made, and reaching out to the health plans,

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doing research ourselves to -- to gather as much information as possible to make a decision.
Q. Do you consider yourself part of the group that made that decision?
A. I would say no.
Q. Who was in the group that made the decision?
A. Legal counsel and the governor's office and the director's office.
Q. Did you consult with anyone in the legislature, particularly the Joint Legislative Budget Committee, JLBC, as to the wisdom of covering surgery for gender dysphoria?
A. No.
Q. Did anyone from the legislature weigh in and tell you their thoughts?
A. No.
Q. Did you ever hear that anyone from the legislature had weighed in and given thoughts on that?
A. No.
Q. Was this considered a political issue of any kind?
A. Not that anyone raised to me, no.
Q. Did you hear secondhand that there was concern about the politics of including surgery for gender dysphoria?
A. No.

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Q. No one ever told you that it was not politically acceptable to provide that coverage if it wasn't required by law?
A. No.
Q. None of your discussions with anyone within ADOA or the governor's office indicated that the political heat was not worth it to cover surgery for gender dysphoria?
A. Not that I recall.
Q. Did you hear it secondhand?
A. Not that I recall.
Q. Do you believe -- Strike that.
Did you believe at the time that there were political costs for expanding the plan to cover surgery for gender dysphoria?
A. I don't remember having an opinion about it.
Q. Did anyone in ADOA or elsewhere express an opinion to you about that?
A. Not that I recollect.
Q. You understood, didn't you, that none of the universities -- strike that -- that the University of Arizona -- neither the University of Arizona nor Arizona State University could provide health benefits that covered surgery for transgender people?
A. Yes.
Q. And why was that?

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A. It was an exclusion in the plan.
Q. It was also in the statute. Do you recall a statutory provision that said that you had to use the -- the State-offered plan?
A. I -- I know that the universities had wanted to not use our plan, to have their own plan. And I -- I do recall that there is a statute that said -- now that you're saying it it does refresh my mind that there is a statute that says the universities have to use the DOA plan.
Q. But there was one university, Northern Arizona, that came within an exclusion because they had coverage beforehand. They had their own -- their own plan and they were able to provide that coverage. And by "that coverage" I mean coverage for surgery, transgender dysphoria surgery.
A. I was aware that U -- that the -- NAU had a grandfathered plan, a Blue Cross Blue Shield plan. I was not aware they covered that.
Q. That never came up in your research?
A. Not that I recall.
Q. Would you describe the reaction of -- How would you describe the reaction of the University of Arizona when you told them that surgery for gender dysphoria was not going to be covered?

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A. I don't remember -- I'm assuming I contacted Helena, but I don't remember -- I don't remember her reaction.
Q. You don't remember that they were extremely unhappy?
A. I'm not surprised if you tell me that, but I don't remember the reaction.
Q. Well, you did know that it was a big issue on the University of Arizona campus.
A. Yes.
Q. They made that clear to you.
A. Yes.
Q. On more than one occasion.
A. Yes.
Q. Do you know how many employees of the State of Arizona were covered by the plan when you left in April of 2018?
A. I don't remember.
Q. Approximately?
A. I know we had 133,000 lives. That's -- that's what I recall.
Q. And do you recall roughly the percentage that were represented by employees at the University of Arizona and Arizona State University?
A. No. But I would say it's about 70,000. I'm

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just -- I remember for each employee it was about two -- two people. So it was about 70,000. And then the universities would have been the other 133 -- Or the difference between 133 and the 70,000 is -- is an approximation.
Q. So if I -- my math is correct, more than half of the people covered by the plan were employees of the University of Arizona and Arizona State University; correct?
A. I'd say a little bit less than half because it was 70,000 that were State and then 63,000 were ASU, U of A, and NAU.
Q. Okay. I got it -- I got it, just reversed.
On how many occasions did you have discussions with representatives of the governor's office about coverage for surgery for gender dysphoria?
A. I don't know. I don't have an exact number. A few times. Several times.
Q. Well, let's start with Tab 36, if you can find that. Should be the last exhibit in the book. And we will mark that as Exhibit 101. We'll call these A -- ABOR 100 and ABOR 101.
On the screen I'll identify it as a string of emails starting with an email from Erica Emmons dated July 21, 2016. And then the middle item in the string is

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an email from Scott Bender to Erica Emmons. And it says that -- and I'm summarizing -- that you had a meeting with the governor's office on transgender issues tomorrow, meaning September 2, 2016, and Scott was asking for additional information, I guess from Cigna, that would help you with the meeting.

Is that a fair summary of that?

A. Yes.

Q. You're not listed as getting a copy on that. Do you recall getting a copy?

A. No.

Q. Is this one of the exhibits you looked at? When was it, last Sunday you were looking at exhibits, or more recently?

A. I know that we looked at exhibits with Erica's name on it. I don't know if this was one of them or not.

Q. Okay. Did you tell Scott that you had this meeting coming up?

A. Based on the email I'm assuming I did.

Q. Do you recall the meeting?

A. I know that I met with the governor's office. I can't tell you that I recall this specific meeting, no.

Q. Do you recall more than one meeting with the governor's office?

A. There's one meeting that sticks out in my mind.

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Q. And do you recall when that meeting took place?

A. I don't. I'm assuming it was around 2016, around this time frame, but I don't really recall.

Q. And why does that stand out?

A. The meeting with the governor's office?

Q. Yes. You said there was one meeting that stood out and I was asking why that particular meeting, whenever it took place, perhaps around September of '16, why does that stick out in your mind?

A. Because that is when the resolution of what we would cover, in my mind, was made.

Q. Who was in that meeting?

A. I think Christina Corieri, Mike Liburdi, Ryan Curtis, myself, I think John Fry from the Attorney General's Office. That's who I recall. Maybe Nicole Ong.

Q. Does Nicole have a last name?

A. Ong, O-N-G.

Q. Okay. And what was her position?

A. She was a general counsel at Arizona Department of Administration.

Q. Were you the only two employees from ADOA who were there?

A. I can't remember if the director was there or not, Craig Brown.

Q. Do you recall what you said at that meeting?

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A. No.

Q. Were you asked to give a report on what other states provided coverage for gender dysphoria surgery?

A. If it's the meeting that I'm recalling, I just remember talking about advice from legal counsel and -- and, you know, what we need to do moving forward, what we're going to do moving forward.

Q. And you had met with legal counsel who told you what was legally required; correct?

A. I don't know if we met or we just communicated via email or phone. Or both.

Q. And you repeated that to the governor's office even though counsel were there?

A. No. I think in advance of the meeting -- again, if it's the same meeting -- I shared the legal advice. It was written. I shared that with Christina Corieri, maybe Mike Liburdi, John Fry, Nicole.

Q. And Mike Liburdi was the counsel for the governor at the time; correct?

A. That's right.

Q. Do you recall how long that meeting lasted?

A. No.

Q. But your recollection is at the end of that meeting you understood that surgery for gender -- gender dysphoria was not going to be covered.

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A. Correct.

Q. And was it based on the fact that it was not legally required?

A. I remember that the discussion was services have to be covered, not specifically surgery, so you could cover counseling and hormone replacement therapy -- or not replacement, hormone therapy, and that that is what we would cover.

Q. Was hormone therapy covered by -- required by the law?

A. I don't remember.

Q. Do you remember discussion about that?

A. Like I said, I just remember that the law requires that services are covered. No specific services are outlined. That's what I recall the discussion being.

Q. I don't understand that answer. Maybe you can help me a little bit. When you say no specific services were -- Did you say out -- outlined or outlawed?

A. What I'm saying is that what I recall is the discussion of what the law requires is that you cover some services, plural, related to transgender gender dysphoria, but nothing -- no specific service is outlined. That's what I recall the discussion --

Q. Okay.

A. -- being.

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Q. Did the plan during the time you had involvement with it cover any services, health services, that were not required by law?
A. I don't know. I mean, I'm sure there are services that aren't required by law that were part of the plan description. The plan was adopted from when we were fully insured. So, you know, I'm assuming there are things that are covered that aren't required.
Q. Do you recall what they might be?
A. I think some plans offered healthy back. You know, that's the one that comes to my mind.
Q. But that was not required by law?
A. Not to my knowledge.
Q. So there was no general policy at ADOA to cover health benefits only if they were required by law; isn't that correct?
A. I would say that's correct.
Q. Other than coverage for healthy backs, can you recall any other services that were not required by law that were offered in the plan?
A. Not off the top of my head, no.
Q. You say that this one meeting took place and may or may not have been around this time in September. We'll look at other documents to see if we can pin it down. Do you recall how many times you did meet with the governor's

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office on this issue?
A. I recall one meeting in the governor's office -- specifically one meeting in the governor's office and at least a phone call with Christina Corieri. Those -- those are the two things that I remember.
Q. Okay. Do you recall whether the telephone call with Christina was before or after the meeting that we've been talking about?
A. I would say there was at least one phone call with her before the meeting.
Q. And what was the nature of that call?
A. I think we're sharing with her that we had engaged Fennemore Craig to do some research.
Q. On the legality, whether it was required by law?
A. Yes.
Q. Okay. And that was it? That was the conversation?
A. As much as I recall, yes.
Q. Did you ever meet with the governor on this issue of surgery for gender dysphoria?
A. No.
Q. Did anyone at ADOA meet with the governor on this issue?
A. I don't know.
Q. Did anyone at the meeting that you've referenced

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at which Mike Liburdi and you and others attended say that they had discussed this matter with the governor?
A. Not that I recall.
Q. Did anyone there say that the governor had a point of view on this issue?
A. Not that I recall.
Q. What position did Scott Bender have at the -- in September of '16 at or around the time this meeting took place?
A. Plan administration manager.
Q. And did he report to you?
A. Yes.
Q. Let's turn to Tab 26. We'll mark that, if it hasn't been marked, as ABOR Exhibit 102. And if you will go to Bates Page Number 119501 of that exhibit, which is the last -- or the first, the first email in this string. You'll see an email from Nicolette Schultz to Jill Metzinger, with a copy of Christina Corieri.
See that?
A. Yes.
Q. It doesn't appear that you got a copy of that email when it was sent in September of 2016. And I'm looking to see whether you were copied on any of the other emails, but I'm not sure that you were.
Do you recall seeing this string of emails

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when you were shown documents?
A. I do.
Q. You do. Okay.
Did you recall it before you saw it?
A. No.
Q. All right. Let's -- let's focus on that very first email which is dated September 1. And it says -- and I'm translating generously, or maybe not so generously -- that there was a discussion at the last meeting regarding transgender benefits that Christina Corieri would like to attend a meeting between the ADOA benefit services -- meaning and you and Nicole Ong -- and the Board of Regents.
Did such a meeting ever take place?
A. I -- I don't remember it.
Q. Do you recall meeting -- a meeting with anyone in the governor's office and you, a meeting with the Board of Regents or anyone in any of the universities?
A. I don't doubt that it could have taken place but I don't remember it.
Q. It's not one that sticks out in your mind?
A. No.
Q. Did they report one to you?
A. No.
Q. They, meaning Nicolette. What's her title? What

about, you know, the nature of depositions. I happen to be a formalist, so you'll just have to bear with me. All right?
A. Okay.
Q. Now, Ms. Isaacson, would you please state your full name and address for the record.
A. Marie Frances Isaacson, 501 West Gleneagles Drive, Phoenix, Arizona, 85023.
Q. And Ms. Isaacson, I believe you said earlier that you were being represented by Mr. Ryan Curtis today at this deposition. Correct?
A. I don't think that he's my attorney, no.
Q. But is he appearing on your behalf today?
A. I understood that I'm just a witness.
Q. Do you have any other legal counsel present with you today during this deposition?
A. No.
Q. And I believe you said earlier that you had been deposed before. Is that right?
A. Long time ago, yes.
Q. What do you mean when you say long time ago?
A. 30 years or more. 40 years maybe. I -- 30- -- 30-some years ago.
Q. And do you recall in what case you were deposed?
A. It was regarding a car accident that I was in.

Q. And where was that car accident?
A. Phoenix, Arizona.
Q. And there was a lawsuit that resulted from that car accident?
A. Yes.
Q. And where was that lawsuit? And by that I mean, before what court?
A. I'm assuming Maricopa County Superior Court, but I don't know.
Q. So although you have been through the gamut of a deposition already this morning I want to just take a step back and go over some ground rules for my own sake, but also yours.
You understand that you are testifying under oath today; correct?
A. Yes.
Q. And is there any reason you can't give truthful testimony today?
A. No.
Q. Are there any medical conditions that would impact your ability to give testimony?
A. No.
Q. And you understand that you need to answer verbally and clearly for the benefit of the court reporter as well as myself and others in the room?

A. Yes.
Q. You have done a great job of that thus far so I don't think we have to belabor it.
Did you bring any documents with you --
A. No.
Q. -- to this deposition?
And you understand that you're not going -- you're not to communicate with anyone else in the room there with you, which I believe is just Mr. Curtis, as well as the general counsel from the Arizona governor's office. Is that right?
MR. CURTIS: Objection; form of the question.
MR. WALL: You can answer, Ms. Isaacson.
THE WITNESS: I'm sorry, could you repeat the question.
Q. BY MR. WALL: Sure. And you understand that during -- while I'm examining you that you're not supposed to be communicating with anyone else in the room with you.
A. Yes.
Q. And that you're not supposed to be looking at your phone.
A. Okay. Yes.
Q. You don't have your phone out; correct?
A. No.

Q. So, again, before we get into questioning I just want to say, you know, if you need a break would you just let me know? The only thing I ask is that you answer my question fully before we take that break.
A. Okay.
Q. Ms. Isaacson?
A. Yes.
Q. Okay. Thank you.
Oh, and finally, you have seen a little bit of this but you understand that your -- rather, I should say your counsel may object to my questions. You should give an -- That's fine. He may object. I will instruct you whether you should answer that question or not or your counsel may direct you not to answer a question.
A. Understood.
Q. So Ms. Isaacson, at the beginning of your examination -- or your conversation with Paul, I believe you said that you were called into the governor's office to discuss this lawsuit. Is that correct?
A. I was -- There was a discussion in the governor's office regarding not the lawsuit, but benefits, coverage of transgender benefits.
Q. And when was that conversation that you're referring to?
A. 2015 or '16.

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Q. And a significant hit would be a half-million dollars?
A. Yes. Or more.
Q. And would that half-million dollars be per month?
A. No. Per event.
Q. So when you say per event -- so for instance, if the -- if there's -- Let's take it as a hypothetical. If the plan excludes coverage for a particular claim, and then that claim has been deemed in, a high cost would be if -- if each claim resulted in an additional half-million dollars spent?
A. What -- what I was saying is, we would look at high-cost claims for each plan, what would -- what happened significant on that plan during the quarter. And so, to me, a high-cost claim would be $500,000 for a member. And that could be, as an example, somebody who was a diabetic who didn't take care of -- didn't take their medication, didn't manage their diabetes properly, had to have an amputation because of it, had to have a second amputation because of it, had complications from it. And so there is a significant cost to the plan. Or a rare disease -- treatment of a rare disease. That -- that's what I was talking about. I was just trying to answer your question about what I consider high costs.
Q. So 500 -- an additional cost of $500,000 to the

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plan per quarter would be a high cost?
A. I -- I was saying that I would look at $500,000 on -- on an incident, a member having an incident of $500,000, I would consider that significant.
Q. I see.
So if it were a claim -- and we might be using the word "claim" and "incident" synonymously. But an incident for a hundred thousand dollars, you wouldn't consider that a high cost?
A. Correct.
Q. And would your assessment depend on -- I think you referenced earlier utilization -- on the number of members having that event per designated period?
A. Yes.
Q. So what utilization would you say would result in a -- in a significant hit to the plan?
A. It could be one time. It could be a onetime event. It could be a premature birth. It could be a car accident. It could be a complication from a surgery. It could be a complication from not managing whatever disease you have. So it's not necessary -- it's not necessarily ongoing utilization, although that could be the case, but, you know, someone with a rare cancer. Those types of things. It could be a onetime event, not necessarily a -- There are ongoing utilization costs and then there are

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onetime costs.
Q. And do you know what percentage of the total annual cost of the plan $500,000 is?
A. Very small.
Q. If you had to guess what would you say?
A. I'm not going to do math here. I don't know.
Q. I don't want to force you to do math.
Do you know, at the time you were the benefits director, what was the average cost of the plan per year?
A. The average cost of the plan per year? The -- the whole benefits program was about a billion dollars. So I -- That was everything. That was employee assistance, dental, vision, health plans.
Q. So going back again to the ADOA's assessment of a new benefit or a change in coverage, does the ADOA ever consider indirect costs?
A. Not that I recall, no.
Q. You mentioned plan savings. Would the ADOA consider plan savings --
A. Yes.
Q. -- when assessing a treatment?
A. Yes.
Q. What about the cost of, say, litigation risk from denying coverage for treatment?

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A. No. That was never discussed.
Q. And where would the ADOA get this information from?
A. Michael Meisner, our actuary. The plans themselves.
Q. So when we're talking about costs there's a tendency to talk about quantitative data. Is there any qualitative data that the ADOA generally considered when assessing new coverage?
A. Yes. I would say yes.
Q. Can you give me some examples?
A. I'll take the gastric sleeve again. The -- the qualitative data on that would have been the outcome for the patient and the quality of the outcome, the -- the -- What am I trying to say? The -- the ultimate outcome, I guess. That it achieved its result.
Q. And by achieving its -- By the ultimate outcome are you referring to coverage in this instance being in the best interest of the plan and the members, as you stated earlier?
A. Yes.
Q. Would you turn for me to Exhibit 38 in that binder. It should be behind Tab 38.
THE COURT REPORTER: And mark it as 38?
MR. WALL: Yes, please. Thank you, Jill.

EXHIBIT 7

In The Matter Of:

Toomey vs.

State of AZ

Scott Bender, Videotaped

March 31, 2021

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,

Plaintiff,

vs. 4:19-CV-00035

STATE OF ARIZONA; ARIZONA BOARD OF REGENTS, d/b/a UNIVERSITY OF ARIZONA, a governmental body of the State of Arizona; et al.,

Defendants.

VIDEOTAPED DEPOSITION OF SCOTT BENDER

Via Zoom Videoconference
March 31, 2021
8:00 a.m.
Phoenix, Arizona

Glennie Reporting Services, LLC
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Prepared by:
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AZ CR No. 50695

I N D E X

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DEPOSITION OF SCOTT BENDER

The deposition of SCOTT BENDER, via Zoom Videoconference, was taken on March 31, 2021, commencing at 8:00 a.m., at Phoenix, Arizona, before ROBIN L. B. OSTERODE, RPR, CSR, California Shorthand Reporter No. 7750 and Arizona Certified Reporter No. 50695.

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APPEARANCES (Continued):

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The Videographer:

Michael Noonan
(Videoconference appearance.)

Also Present:

Kimberly Suciu
(Videoconference appearance.)

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THE VIDEOGRAPHER: We are on the record. Today's date is March 31st, 2021. The time on the video monitor is 8:05 a.m., standard time. Here begins video number one in the deposition of Scott Bender, in the matter of Russell B. Toomey versus State of Arizona, et al., in the United States District Court, District of Arizona, case number 4:19-CV-00035.

The court reporter is Robin Osterode representing Glennie Reporting Services, 1555 East Orangewood Avenue, Phoenix, Arizona 85020.

My name is Michael Noonan. I'm the certified legal video specialist, in association with Forensic Video Deposition Services, 11111 North Scottsdale Road, Suite 205, Scottsdale, Arizona 85254.

This deposition is taking place at the law offices of Fennemore Craig, 2394 East Camelback Road, Suite 600, Phoenix, Arizona 85016.

Counsel will now state their appearance and affiliations and everyone attending remotely and anyone else present in the room for the record, please, beginning with the plaintiffs.

MR. WALL: Good morning. This is Jordan Wall, from Willkie Farr & Gallagher, on behalf of the plaintiff Dr. Russell B. Toomey and certified classes. I'm joined by my colleagues, Victoria Sheets and Justin Garbacz in the room, and, on remotely, Brandon Villa.

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MR. CURTIS: Good morning. This is Ryan Curtis with Fennemore Craig on behalf of the State defendants and Andy Tobin and Paul Shannon in their official capacity. Also in the room with me is Kim Suciu, associate general counsel for the Arizona Department of Administration.

MR. YOST: Good morning. This is Austin Yost on behalf of the Arizona Board of Regents. Also with me remotely is Paul Eckstein.

THE VIDEOGRAPHER: I apologize. Robin, did you get all that?

THE REPORTER: I did.

THE VIDEOGRAPHER: Would you please swear in the witness.

THE REPORTER: Before we proceed, I will ask counsel to agree on the record that there is no objection to this officer of the court administering a binding oath to a witness not appearing personally before me.

Please state your agreement on the record.

MR. CURTIS: State defendants have no objection.

MR. YOST: University defendants have no objection.

MR. WALL: Plaintiff has no objection.

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SCOTT BENDER,
called as a witness herein, having been first duly sworn by the Certified Reporter to speak the whole truth and nothing but the truth, was examined and testified as follows:

THE VIDEOGRAPHER: Please begin when ready.

EXAMINATION

BY MR. WALL:

Q. Good morning, Mr. Bender. How are you?
A. I'm doing well, thanks. How are you?
Q. I'm doing all right.
Would you please state your full name and address for the record?
A. Yes. Scott Patrick Bender. My address is 893 South Gardner Drive, Chandler, Arizona 85224.
Q. And, Mr. Bender, are you being represented by Mr. Ryan Curtis today at this deposition?
A. Yes.
Q. And have you ever been deposed before?
A. No.
Q. Have you ever testified at trial?
A. No.
Q. Okay. So I'm going to go over some ground

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Q. And that was intended to provide -- to remove the exclusion of medical and psychological counseling and hormone therapy in connection with what had been called transsexual surgery, but still exclude transsexual surgery?
A. That's correct.
Q. What prompted this change?
A. I don't know.
Q. Do you know what prompted the ADOA's assessment of whether to maintain this exclusion or modify it?
A. No. Whatever conversations Marie had with the governor's office we weren't privy to.
Q. Let me clarify, Mr. Bender. I'm not asking what was the reason for the change, not yet, but I'm asking you why was the ADOA looking at this exclusion to begin with?
A. Well, the exclusion had always existed. It was anticipation of action under 1557 and the final rules being proposed and what that would look like.
Q. And so what was it about 1557 that prompted the ADOA to examine the exclusion of transgender benefits?
A. We needed to understand what our obligations would be if we were required to cover the transgender benefits.
Q. What was it that the ADOA needed to understand

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with respect to Section 1557?
A. We needed to understand if we were required to cover all transgender benefits or if it was going to be optional as a self-insured plan. We need to be a compliant plan. And if we're required to cover something, we need to do so. And if we're not, we need to consider whether we should or should not.
Q. So the ADOA was assessing the plan's exclusion of transgender benefits, because they needed to understand whether it complied with Section 1557?
A. Whether we complied and if we needed to comply.
Q. So the ADOA was assessing the plan's exclusion of transgender benefits to understand whether it complied with -- whether it needed to comply with Section 1557, and if so, whether it did comply with Section 1557?
A. Correct.
Q. The ADOA could have avoided this -- this question by simply removing the exclusion on transgender benefits, couldn't it have?
MR. CURTIS: Objection; form of the question.
BY MR. WALL:
Q. You can answer, Mr. Bender.
THE WITNESS: Can I answer?
MR. CURTIS: You can answer.
THE WITNESS: Yes, we could have just accepted

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or deleted the exclusions and absorbed the costs associated with that, for sure.
BY MR. WALL:
Q. So if the ADOA had removed the exclusion listed in paragraph 16, would there have been any other question about the ADOA's compliance with Section 1557?
A. From a compliance standpoint, no. If we voluntarily opted in, there's no compliance issue.
Q. So why didn't the ADOA remove the exclusion for all transgender benefits under the plan?
A. Can you rephrase?
Q. Why didn't the ADOA remove the plan's exclusion of transgender benefits, inclusive of gender reassignment surgery?
A. I believe there are several reasons, one being cost and the other being we didn't feel it was required for us to include -- or to eliminate the exclusion for.
Q. So the ADOA did not remove the plan's exclusion of gender reassignment surgery because of cost, and it didn't feel it was required to remove that exclusion?
A. Those are both reasons. I think, primarily, is we weren't required to, and if we're not required to, then we weren't interested in taking on additional costs in a plan that's already under water.
Q. The ADOA's primary reason for not removing the

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exclusion of gender reassignment surgery is because it was not required to?
A. That's my understanding.
Q. But, additionally, the ADOA wasn't interested in taking on additional costs in the plan --
A. If we were --
Q. -- from providing these services?
A. That's correct. If we weren't required to, we weren't going to take on the additional cost.
Q. The ADOA wasn't required to provide coverage for counseling services and hormone therapy in connection with transgender -- gender reassignment surgery?
MR. CURTIS: Objection; form of the question.
BY MR. WALL:
Q. You can answer, Mr. Bender, or would you like me to repeat it?
A. Can you repeat, please?
Q. The ADOA was not required to provide coverage for counseling services and hormone therapy in connection with gender reassignment surgery, was it?
A. Not -- that is -- that is correct.
Q. But the ADOA still provided coverage for those services?
A. Yes.
Q. The ADOA was not required to provide 3-D

EXHIBIT 8

WILLKIE FARR & GALLAGHER LLP

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April 28, 2021

VIA EMAIL

Ryan Curtis, Esq.
Shannon Cohan, Esq.
Fennemore Craig, P.C.
2394 E. Camelback Road, Suite 600
Phoenix, Arizona 85061

Re: *Russell B. Toomey, v. State of Arizona, et al,* No. CV-19-00035-TUC-RM (LAB)

Dear Ryan and Shannon:

We write with respect to the State of Arizona, Andy Tobin, and Paul Shannon's (collectively, the "State Defendants") withholding of documents based on attorney client privilege.

As evidenced by the State of Arizona's Privilege/Redaction log, the State Defendants are withholding communications involving legal advice provided to the State Defendant's regarding the State's self-funded healthcare plan's exclusion for "gender reassignment surgery" (the "Exclusion"). As outlined below, the State Defendants have waived attorney client privilege with respect to legal advice that was considered by the State Defendants in their decision to maintain the Exclusion in two ways: *first*, by affirmatively relying on legal advice as a basis for denying discriminatory intent in this litigation; and *second*, by disclosing the substance of the legal advice to Dr. Toomey and his counsel in the course of Marie Isaacson's March 26th deposition.

I. State Defendants Have Waived The Attorney-Client Privilege By Asserting Legal Advice As A Defense To Claims Of Intentional Discrimination.

When a party relies on advice of counsel as a defense, it cannot assert the attorney-client privilege to shield that advice from discovery. *Chevron Corp. v. Pennzoil Co*., 974 F.2d 1156, 1162-63 (9th Cir. 1992); *U.S. v. Kerr*, CR 11-2385-PHX-JAT, 2012 WL 2919450, at *3 (D. Ariz. July 17, 2012). This is

particularly true where a party has denied having any improper motive or intent based on their supposed reliance on advice of counsel. *Id.*

Courts in the Ninth Circuit apply a three-pronged test to determine whether a waiver has occurred:

> First, the court considers whether the party is asserting the privilege as the result of some affirmative act, such as filing suit. . . . Second, the court examines whether through this affirmative act, the asserting party puts the privileged information at issue. . . . Finally, the court evaluates whether allowing the privilege would deny the opposing party access to information vital to its defense.

United States v. Amlani, 169 F.3d 1189, 1195 (9th Cir. 1999) (citations and quotations omitted); *see also Chevron Corp.*, 974 F.2d at 1162-63 (finding defendant had waived attorney-client privilege by affirmatively relying on legal advice to support the reasonableness of its actions); *see also Melendres v. Arpaio*, CV-07-2513-PHX-GMS, 2015 WL 12911719, at *2 (D. Ariz. May 14, 2015) (finding waiver for all communications, documents referencing such communications, and for all work product used in formulating the advice communicated to Defendants). All three factors support a finding that State Defendants have waived the attorney-client privilege with respect to the decision to maintain the Exclusion.

First, State Defendants have affirmatively asserted, in both their Answer and recent Supplemental Responses to Dr. Toomey's Interrogatory No. 1, the advice of counsel as a principal rationale[1] for maintaining the Exclusion and denying any claim of discriminatory intent. State Defendants' Answer at Affirmative Defenses J and M (Doc. No. 89); State Defendant's Supplemental Responses to Plaintiff's First Set of Interrogatories at Answer to Interrogatory No. 1 (citing "legal advice that the State received" as a basis for maintaining the Exclusion, and specifically, advice from counsel that "it was not legally required to change its health plan to provide [coverage for gender reassignment surgery]. . . .")

Second, State Defendants have unquestionably put the privileged information at issue, both in writing through their Answer and Supplemental Responses, and testimony from key witnesses. During her deposition on March 22, 2021, Marie Isaacson, Director of the Benefits Services Division of the ADOA during 2016, stated that "the deciding factor" for ADOA's decision to exclude gender reassignment surgery was "what was required by law." *See* Isaacson Tr. at 31:16-17. Ms. Isaacson also testified that the final decision was made by a small group, including the Governor's Office and legal counsel. *Id.* at 32:7. Ms. Isaacson testified that she herself, as Director of the ADOA Benefits Services

[1] State Defendants also cite cost as another non-discriminatory basis for maintaining the Exclusion, but the salience of this rationale has been undermined by the State's own witnesses. *See* Isaacson Tr. at 31:13-15 (testifying that cost was not "the driving factor" in ADOA's decision, and that instead legal advice that ADOA was not required to cover gender reassignment surgery was the principal rationale); Bender Tr. at 167:12 – 168:3 (testifying that cost was secondary, and that advice about what ADOA was required or not required to cover was the primary basis of ADOA's decision).

Division, did not provide an opinion one way or another about coverage, and that the decision was instead based principally on legal advice. *Id.* at 49:8-50:11.

In other words, Ms. Isaacson testified that the advice of counsel regarding whether ADOA was required to cover gender reassignment surgery was front-and-center to ADOA's decision-making over the Exclusion—one of the central issues in this litigation.

Third, the information being withheld by State Defendants is undeniably vital to the case, as it goes to the heart of the State Defendant's rationale for maintaining the Exclusion. The Court has recently recognized that this issue remains a live and critical one in the present dispute. (Doc. No. 187 at 5.) Having asserted legal advice as a defense and a rationale for their decision not to cover gender reassignment surgery, the State Defendants cannot continue to withhold documents and communications regarding that advice. Fairness here requires disclosure.

State Defendants have therefore waived the attorney-client privilege with respect to any documents and communications evidencing legal advice that was relied on by the State Defendants in their decision-making regarding the Exclusion.

II. State Defendants Have Alternatively Waived The Attorney-Client Privilege Through Disclosure.

Separately, the State Defendants have waived privilege with respect to legal advice that was provided to them regarding the Exclusion because the content of this advice was disclosed during Marie Isaacson's March 26, 2021 deposition.

"[I]t has been widely held that voluntary disclosure of the content of a privileged attorney communication constitutes waiver of the privilege as to all other such communications on the same subject." *Weil v. Inv./Indicators, Research and Mgt., Inc*., 647 F.2d 18, 24 (9th Cir. 1981); *cf. Hernandez v. Tanninen*, 604 F.3d 1095, 1100-01 (9th Cir. 2010) (affirming waiver of privilege as to certain subjects, but reversing blanket waiver of all privilege). Such a waiver-by-disclosure can occur during a deposition, when a witness voluntarily discloses legal advice. *See Weil, 647 F.2d* at 24 (holding that party asserting privilege had waived the privilege with respect to legal advice after its director disclosed the substance of the legal advice during deposition); *see also Thomas v. F.F. Fin., Inc*., 128 F.R.D. 192, 192-94 (S.D.N.Y. 1989) (finding that deponent waived privileged information by disclosure during deposition). The fact that the disclosing party did not "subjectively intend to waive the privilege is insufficient to make out the necessary element of non-wavier." *Weil*, 647 F.2d at 25; *id.* at n.13 ("[W]hen, as here, the privileged communication is voluntarily disclosed without objection by the asserting party's counsel and in the absence of surprise or deception by opposing counsel, it may be unnecessary to look beyond the objective fact of disclosure in ruling on the question of waiver.")

During her deposition, Ms. Isaacson voluntarily disclosed that ADOA was advised by counsel that "some services" were required to be covered, but gender reassignment surgery in particular was "not required to be covered." *See* Isaacson Tr. at 19:18-24. While State Defendant's counsel made an objection shortly after this testimony, advising Isaacson not to "speak to direct legal counsel received,"

this did not prevent Isaacson from later confirming that legal counsel had advised ADOA that coverage was "not required by law." *See id.* at 20:10-15. Ms. Isaacson's disclosures amounted to a waiver "as to all other communications on the same subject." *Hernandez*, 604 F.3d at 1100. The subject of the disclosed advice was whether ADOA is required by law to cover gender reassignment surgery.

State Defendants have waived privilege for, and must produce, all documents and communications with counsel regarding the question of whether ADOA was legally required to cover gender reassignment surgery that are being withheld on the basis of the attorney-client privilege.

***

For the reasons outlined above, State Defendants have waived the attorney-client privilege with respect to any documents and communications with counsel regarding the question of whether ADOA was legally required to cover gender reassignment surgery. Dr. Toomey requests therefore that State Defendants produce as soon as practicable all documents and communications with counsel on this topic that are currently being withheld on the basis of the attorney-client privilege, and furthermore revise their Privilege/Redaction Log, to remove any such documents therefrom.

This letter is not intended to address all of Dr. Toomey's issues with the State Defendants' document production or its claims to privilege. Nothing in this letter is intended to waive or limit in any way Dr. Toomey's rights to raise other issues not stated here.

Please let us know if you have any questions, and if you are able to meet and confer this week or next on the issues raised herein.

Sincerely,

/s/ Wesley R. Powell
Wesley R. Powell
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New York, NY 10019-6099

Attachments:

- Excerpts of Isaacson Tr.
- Excerpts of Bender Tr.

cc. Joshua A. Block

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EXHIBIT 9

State of Arizona Privilege/ Redaction Log

No.	*DocID/ Beg Bates No.*	*DocID/ End Bates No.*	*Date*	*From/ Author*	*To*	*CC*	*Privilege Type*	*Subject/ Description*
1	EML00006426	EML00006426	6/27/2016	Marie Isaacson	Erwin Kratz; Scott Bender	Rose Bernal; Jennifer Bowling; Gail Goodman; Ryan Curtis	Attorney-Client Communication	RE: Memorandum regarding leave, premiums, termination dates, and ACA Hours of Service (ADOA Benefits questions)
2	EML00006427	EML00006428	6/24/2016	Jennifer Bowling	Marie Isaacson; Scott Bender; Rose Bernal	Jennifer Bowling	Attorney-Client Communication	RE: State of AZ benefit plan forms and documents
3	EML00007337	EML00007337	8/2/2016	Elizabeth Schafer	Marie Isaacson		Attorney-Client Communication	re: draft cover memo 1557 Rule
4, 5	EML00007338	EML00007339	8/2/2016	Elizabeth Schafer	Marie Isaacson	Yvette Medina	Attorney-Client Communication	re: draft cover memo 1557 Rule
6	AZSTATE.005551	AZSTATE.005554	1/13/2017	Marie Isaacson	Nicolette A Schultz		Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	re: plan document updates
7	AZSTATE.246030	AZSTATE.246033	1/13/2017	Nicolette A Schultz	Marie Isaacson		Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	re: plan document updates
8	EML00012642	EML00012644	10/19/2016	Ryan Curtis	Marie Isaacson	Nicole Ong; John Fry; Erwin Kratz	Attorney-Client Communication	ACA 1557 Implementation [FC-Email.FID7081187]
9	EML00012648	EML00012648	10/18/2016	Marie Isaacson	Ryan Curtis	Nicole Ong; John Fry	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
10	EML00012649	EML00012650	10/18/2016	Ryan Curtis	Marie Isaacson	Nicole Ong; John Fry	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
11	EML00012651	EML00012651	10/18/2016	Nicole Ong	Marie Isaacson		Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
12	EML00012656	EML00012656	10/17/2016	Marie Isaacson	Ryan Curtis; John Fry	Nicole Ong; Nicolette A Schultz	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
13	EML00012660	EML00012660	10/17/2016	Marie Isaacson	John Fry; Ryan Curtis	Nicole Ong	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
14	EML00012661	EML00012661	10/17/2016	Fry, John	Marie Isaacson; Ryan Curtis	Nicole Ong	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
15	EML00012662	EML00012662	10/17/2016	Marie Isaacson	Ryan Curtis; John Fry	Nicole Ong	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
16	EML00012663	EML00012663	10/17/2016	Ryan Curtis	Fry, John; Marie Isaacson	Nicole Ong	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]

State of Arizona Privilege/ Redaction Log

No.	*DocID/ Beg Bates No.*	*DocID/ End Bates No.*	*Date*	*From/ Author*	*To*	*CC*	*Privilege Type*	*Subject/ Description*
17	EML00012664	EML00012664	10/17/2016	John Fry	Marie Isaacson; Ryan Curtis	Nicole Ong	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
18	EML00012665	EML00012665	10/17/2016	Marie Isaacson	Ryan Curtis	John Fry; Nicole Ong	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
19	EML00012676	EML00012676	10/11/2016	Ryan Curtis	Marie Isaacson	John Fry; Erwin Kratz	Attorney-Client Communication	RE: ACA § 1557 - Short update call [FC-Email.FID7081187]
20	EML00012867	EML00012868	8/3/2016	Marie Isaacson	Elizabeth Schafer		Attorney-Client Communication; Deliberative Process Privilege	Draft cover memo 1557 Rule
21	EML00012874	EML00012875	8/2/2016	Marie Isaacson	Elizabeth Schafer, Yvette Medina		Attorney-Client Communication; Deliberative Process Privilege	Draft cover memo 1557 Rule
22, 23	EML00012878	EML00012888	8/1/2016	Marie Isaacson	Yvette Medina; Scott Bender; Elizabeth Schafer		Attorney-Client Communication	FW: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
24	EML00012889	EML00012889	7/27/2016	Nicolette A Schultz	Ryan Curtis; Marie Isaacson	Cindy Shupe; Erwin Kratz	Attorney-Client Communication	RE: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
25	EML00012890	EML00012890	7/27/2016	Ryan Curtis	Marie Isaacson	Cindy Shupe; Erwin Kratz; Nicolette A Schultz	Attorney-Client Communication	RE: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
26	EML00012891	EML00012891	7/27/2016	Marie Isaacson	Ryan Curtis	Cindy Shupe; Erwin Kratz; Nicolette A Schultz	Attorney-Client Communication	RE: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
27	EML00012893	EML00012898	7/26/2016	John Fry	Marie Isaacson		Attorney-Client Communication	Re: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
28, 29	EML00012899	EML00012908	7/25/2016	Marie Isaacson	John Fry	Nicolette A Schultz	Attorney-Client Communication	FW: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
30	EML00012909	EML00012909	7/22/2016	Marie Isaacson	Ryan Curtis	Cindy Shupe; Erwin Kratz	Attorney-Client Communication	RE: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
31, 32	EML00012910	EML00012919	7/22/2016	Ryan Curtis	Marie Isaacson	Cindy Shupe; Erwin Kratz	Attorney-Client Communication	ACA 1557 - Discrimination and Gender Identity
33	EML00013079	EML00013098	5/25/2016	Marie Isaacson	Erwin Kratz		Attorney-Client Communication	FW: Materials regarding our Health Plans
34	EML00014080	EML00014080	11/20/2019	Michael Meisner	Scott Bender	Paul Shannon	Attorney-Client Communication	Re: draft - Gender dysphoria issues to Kate King CONFIDENTIAL 11-20-19 - Invitation to edit
35	EML00014082	EML00014082	11/19/2019	Scott Bender	Paul Shannon	Michael Meisner	Attorney-Client Communication	Re: draft - Gender dysphoria issues to Kate King CONFIDENTIAL 11-20-19 - Invitation to edit
36	EML00014083	EML00014083	11/19/2019	Paul Shannon	Michael Meisner	Scott Bender	Attorney-Client Communication	draft - Gender dysphoria issues to Kate King CONFIDENTIAL 11-20-19 - Invitation to edit
37	EML00014130	EML00014130	10/30/2019	Michael Meisner	Paul Shannon	Scott Bender	Attorney-Client Communication	Re: United Healthcare - Gender Dysphoria Treatment
38	EML00014131	EML00014131	10/29/2019	Paul Shannon	Michael Meisner; Scott Bender		Attorney-Client Communication	Fwd: United Healthcare - Gender Dysphoria Treatment

State of Arizona Privilege/ Redaction Log

No.	DocID/ Beg Bates No.	DocID/ End Bates No.	Date	From/ Author	To	CC	Privilege Type	Subject/ Description
39	EML00014160	EML00014160	10/8/2019	Michael Meisner	Scott Bender		Attorney-Client Communication	Re: Toomey v. State of AZ
40	EML00014161	EML00014161	10/8/2019	Scott Bender	Michael Meisner		Attorney-Client Communication	Fwd: Toomey v. State of AZ
41	EML00014186	EML00014186	10/1/2019	Michael Meisner	Scott Bender		Attorney-Client Communication	Re: United Healthcare transgender benefit
42	EML00014196	EML00014196	9/30/2019	Scott Bender	Michael Meisner		Attorney-Client Communication	Fwd: United Healthcare transgender benefit
43	EML00014200	EML00014200	9/26/2019	Scott Bender	Michael Meisner		Attorney-Client Communication	Fwd: United Healthcare transgender benefit
44	EML00014201	EML00014201	9/26/2019	Michael Meisner	Scott Bender		Attorney-Client Communication	Re: United Healthcare transgender benefit
45	EML00014202	EML00014202	9/26/2019	Scott Bender	Michael Meisner		Attorney-Client Communication	Fwd: United Healthcare transgender benefit
46, 47	EML00014215	EML00014216	9/23/2019	Michael Meisner	Scott.Bender; Paul Shannon		Work-Product	Re: Estimated annual costs to included transgender benefits: $11 million per year
48	EML00014218	EML00014218	9/23/2019	Michael Meisner	Scott.Bender; Paul Shannon		Work-Product	Estimated annual costs to included transgender benefits: $11 million per year
49	EML00018839	EML00018839						**DOCUMENT PRODUCED OFF OF PRIVILEGE LOG**
50	AZSTATE.246049	AZSTATE.246052	1/13/2017	Yvette Medina	Nicolette A Schultz		Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	FW: ACA §1557 Non-Discrimination
51	EML00019822	EML00019822	7/27/2016	Nicolette A Schultz	Ryan Curtis		Attorney-Client Communication	RE: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
52	EML00019823	EML00019823	7/27/2016	Ryan Curtis	Nicolette A Schultz		Attorney-Client Communication	RE: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
53	EML00019824	EML00019824	7/27/2016	Nicolette A Schultz	Ryan Curtis		Attorney-Client Communication	RE: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
54	EML00019825	EML00019825	7/27/2016	Ryan Curtis	Nicolette A Schultz		Attorney-Client Communication	RE: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
55	EML00019829	EML00019829	7/27/2016	Nicolette A Schultz	John Fry		Attorney-Client Communication	RE: Scheduling meeting for ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
56	EML00019830	EML00019830	7/27/2016	Nicolette A Schultz	John Fry		Attorney-Client Communication	RE: Scheduling meeting for ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
57	EML00019831	EML00019836	7/27/2016	John Fry	Nicolette A Schultz		Attorney-Client Communication	Re: Scheduling meeting for ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]

State of Arizona Privilege/ Redaction Log

No.	*DocID/ Beg Bates No.*	*DocID/ End Bates No.*	*Date*	*From/ Author*	*To*	*CC*	*Privilege Type*	*Subject/ Description*
58	EML00019837	EML00019837	7/27/2016	Nicolette A Schultz	John Fry		Attorney-Client Communication	RE: Scheduling meeting for ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
59	EML00019838	EML00019838	7/26/2016	John Fry	Nicolette A Schultz		Attorney-Client Communication	RE: Scheduling meeting for ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
60	EML00019839	EML00019839	7/26/2016	Nicolette A Schultz	John Fry		Attorney-Client Communication	Scheduling meeting for ACA 1557 - Discrimination and Gender Identity
61	EML00021020	EML00021020	1/8/2016	Michael Bailey	Marc Lamber	Marie Isaacson; Rex Nowlan	Attorney-Client Communication	Authorization for Outside Counsel to Provide Periodic Advice to the Arizoan Department of Administration on Health and Employee Welfare Questions
62	EML00021053	EML00021053	12/11/2019	Scott Bender	Nicole Sornsin; Kimberly Suciu; Paul Shannon		Attorney-Client Communication	Gender Reassignment services appeal
63	EML00021133	EML00021133						**DOCUMENT PRODUCED OFF OF PRIVILEGE LOG**
64, 65	EML00021178	EML00021179	9/23/2019	Michael Meisner	Scott.Bender; Paul Shannon		Work-Product	Re: Estimated annual costs to included transgender benefits: $11 million per year
66	EML00021181	EML00021181	9/23/2019	Michael Meisner	Scott.Bender; Paul Shannon		Work-Product	ADOA Estimated annual costs
67	AZSTATE.246062	AZSTATE.246067	2/19/2019	Scott Bender	Paul Shannon		Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	Fwd: FW: ACA §1557 Non-Discrimination
68	EML00021298	EML00021298						**DOCUMENT PRODUCED OFF OF PRIVILEGE LOG**
69	EML00021303	EML00021303						**DOCUMENT PRODUCED OFF OF PRIVILEGE LOG**
70	AZSTATE.246068	AZSTATE.246072	10/25/2018	Yvette Medina	Scott Bender		Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	Fwd: FW: ACA §1557 Non-Discrimination
71	AZSTATE.246097	AZSTATE.246101	10/25/2018	Yvette Medina	Scott Bender		Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	Fwd: FW: ACA §1557 Non-Discrimination
72	ESI00000686	ESI00000686	7/20/2016	Ryan Curtis	Marie Isaacson		Attorney-Client Communication	Summary and Implications of ACA § 1557 and Transgender Coverage Requirements
73	ESI00000688	ESI00000688	2/5/2019	Paul Shannon	Nicole Sornsin		Attorney-Client Communication	Re: Plan Exceptions
74	ESI00000689	ESI00000689	2/5/2019	Paul Shannon	Nicole Sornsin		Attorney-Client Communication	Re: Plan Exceptions
75	ESI00000690	ESI00000690	8/3/2016	Marie Isaacson	Mike Liburdi		Attorney-Client Communication; Deliberative Process Privilege	Affordable Care Act § 1557, Non-discrimination - Transgender Coverage
76	AZSTATE.246104	AZSTATE.246108	12/15/2016	Marie Isaacson	Christina Corieri	Scott Bender; Nicole Ong	Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	RE: ACA §1557 Non-Discrimination
77							ENTRY NUMBER INADVERTENTLY OMITTED	
78	ESI00000700	ESI00000700	7/20/2016	Ryan Curtis	Marie Isaacson		Attorney-Client Communication	Summary and Implications of ACA § 1557 and Transgender Coverage Requirements

State of Arizona Privilege/ Redaction Log

No.	*DocID/ Beg Bates No.*	*DocID/ End Bates No.*	*Date*	*From/ Author*	*To*	*CC*	*Privilege Type*	*Subject/ Description*
79	ESI00000701	ESI00000701	7/20/2016	Ryan Curtis	Marie Isaacson		Attorney-Client Communication	Summary and Implications of ACA § 1557 and Transgender Coverage Requirements
80	ESI00000702	ESI00000702	8/1/2016	Marie Isaacson	Yvette Medina; Scott Bender; Elizabeth Schafer		Attorney-Client Communication	FW: ACA 1557 - Discrimination and Gender Identity [FC-Email.FID7081187]
81	ESI00000703	ESI00000703	7/6/2016	Marie Isaacson	Erwin Kratz	Ryan Curtis; Cindy Shupe; Scott Bender	Attorney-Client Communication	RE: The Plan Participation Chart we Discussed [FC-Email.FID7081187]
82	ESI00000772	ESI00000772	7/20/2016	Ryan Curtis	Marie Isaacson		Attorney-Client Communication	Summary and Implications of ACA § 1557 and Transgender Coverage Requirements
83	ESI00000773	ESI00000773	2/5/2019	Paul Shannon	Nicole Sornsin		Attorney-Client Communication	Re: Plan Exceptions
84	AZSTATE.000784	AZSTATE.001365						**DOCUMENT PRODUCED IN UNREDACTED FORMAT**
85	AZSTATE.001366	AZSTATE.001678						**DOCUMENT PRODUCED IN UNREDACTED FORMAT**
86	AZSTATE.001679	AZSTATE.001695						**DOCUMENT PRODUCED IN UNREDACTED FORMAT**
87	AZSTATE.001696	AZSTATE.001778						**DOCUMENT PRODUCED IN UNREDACTED FORMAT**
88	AZSTATE.001779	AZSTATE.002089						**DOCUMENT PRODUCED IN UNREDACTED FORMAT**
89	AZSTATE.002090	AZSTATE.002751						**DOCUMENT PRODUCED IN UNREDACTED FORMAT**
90	AZSTATE.003186	AZSTATE.003188	1/17/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
91	AZSTATE.003438	AZSTATE.003454						**DOCUMENT PRODUCED IN UNREDACTED FORMAT**
92	AZSTATE.003466	AZSTATE.003467	1/17/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
93	AZSTATE.005416	AZSTATE.005418	1/17/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
94	AZSTATE.005541	AZSTATE.005541	1/26/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
95	AZSTATE.005547	AZSTATE.005548	1/17/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
96	AZSTATE.006534	AZSTATE.006536	1/13/2020	Scott Bender	Paul Shannon		HIPAA/Personally Identifiable Information	Fwd: Harmful exclusions from state healthcare plan.msg
97	AZSTATE.006880	AZSTATE.006880	8/23/2017	Rose Bernal	Scott Bender; Erin King; Kayla Stivason		HIPAA/Personally Identifiable Information	FW: Additional Information - Appeal.msg
98	AZSTATE.007001	AZSTATE.007001	8/23/2017	Rose Bernal	Staci Wilson	[REDACTED]	HIPAA/Personally Identifiable Information	RE: Additional Information - Appeal.msg
99	AZSTATE.007002	AZSTATE.007003	8/21/2017	Rose Bernal	[REDACTED]	Staci R. Wilson; Helena A. Rodrigues; Kayla Stivason	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure.msg
100	AZSTATE.007004	AZSTATE.007005	8/1/2017	Staci Wilson	Rose Bernal		HIPAA/Personally Identifiable Information	RE: Transgender coverage - hormone therapy.msg
101	AZSTATE.007006	AZSTATE.007007	8/1/2017	Shannon Daniel	Rose Bernal	Yvette Medina; Scott Bender	HIPAA/Personally Identifiable Information	RE: Transgender coverage - hormone therapy.msg
102	AZSTATE.009655	AZSTATE.009659						**DOCUMENT PRODUCED IN UNREDACTED FORMAT**
103	AZSTATE.010325	AZSTATE.010325	4/22/2019				HIPAA/Personally Identifiable Information	Report of ADOA transgender services from Aetna
104	AZSTATE.010904	AZSTATE.010904	1/26/2017				Confidential, non-relevant information	Draft meeting Agenda
105	AZSTATE.011038	AZSTATE.011045	9/29/2016				Confidential, non-relevant information	Draft Medical Director Meeting Minutes
106	AZSTATE.011046	AZSTATE.011049	9/28/2016	Eveleth, Ray G <EvelethR@aetna.com>	Scott Bender <Scott.Bender@azdoa.gov>; Yvette Medina <Yvette.Medina@azdoa.gov>	Dash, Jay A.	Confidential, non-relevant information	RE: Medical director meeting.msg
107	AZSTATE.080734	AZSTATE.080738	1/25/2017				HIPAA/Personally Identifiable Information	Session Roster - 2017 Benefits Liaison Training
108	AZSTATE.080739	AZSTATE.080739	1/25/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda

State of Arizona Privilege/ Redaction Log

No.	DocID/ Beg Bates No.	DocID/ End Bates No.	Date	From/ Author	To	CC	Privilege Type	Subject/ Description
109	AZSTATE.083158	AZSTATE.083159	1/17/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
110	AZSTATE.083937	AZSTATE.083940	6/24/2016	Marie Isaacson	Jennifer Bowling; Scott Bender; Rose Bernal		Attorney-Client Communication	RE: State of AZ benefit plan forms and documents [FC-Email.FID7081187]
111	AZSTATE.083941	AZSTATE.083944	6/24/2016	Marie Isaacson	Scott Bender; Jennifer Bowling; Rose Bernal		Attorney-Client Communication	FW: State of AZ benefit plan forms and documents [FC-Email.FID7081187]
112	AZSTATE.084769	AZSTATE.084769	5/22/2017	Elizabeth Schafer			HIPAA/Personally Identifiable Information	Blue Cross Blue Shield of Arizona member Satisfaction Survey Results
113	AZSTATE.085648	AZSTATE.085649	6/8/2016	Elizabeth Schafer	Scott Bender		Attorney-Client Communication	Re: Transgender benefits
114	AZSTATE.085875	AZSTATE.085875	5/27/2016	Elizabeth Schafer			HIPAA/Personally Identifiable Information	UnitedHealthcare member Satisfaction Survey Results
115	AZSTATE.085877	AZSTATE.085877	5/11/2016	Elizabeth Schafer			HIPAA/Personally Identifiable Information	UnitedHealthcare member Satisfaction Survey Results
116	AZSTATE.088316	AZSTATE.088316	6/28/2018				HIPAA/Personally Identifiable Information	UnitedHealthcare member Satisfaction Survey Results
117	AZSTATE.088872	AZSTATE.088878	8/25/2017	Scott Bender	Mary Cappabianco; Erin Russell; Kayla Stivason; Rose Bernal	Sean Kirwan	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
118	AZSTATE.088879	AZSTATE.088885	8/25/2017	Mary Cappabianco	Scott Bender; Erin Russell; Kayla Stivason; Rose Bernal	Sean Kirwan	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
119	AZSTATE.088886	AZSTATE.088891	8/25/2017	Scott Bender	Erin Russell; Kayla Stivason; Rose Bernal	Sean Kirwan; Mary Cappabianco	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
120	AZSTATE.088892	AZSTATE.088897	8/24/2017	Erin Russell	Kayla Stivason; Rose Bernal	Scott Bender; Sean Kirwan; Mary Cappabianco	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
121	AZSTATE.088898	AZSTATE.088902	8/23/2017	Kayla Stivason	Erin Russell; Rose Bernal	Scott Bender; Sean Kirwan	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
122	AZSTATE.089023	AZSTATE.089026	8/22/2017	Erin Russell	Rose Bernal; Kayla Stivason	Scott Bender; Sean Kirwan	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
123	AZSTATE.094671	AZSTATE.094675	1/25/2017				HIPAA/Personally Identifiable Information	Session Roster - 2017 Benefits Liaison Training
124	AZSTATE.094676	AZSTATE.094676	1/26/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
125	AZSTATE.095605	AZSTATE.095608	1/13/2017	Marie Isaacson	Nicolette A Schultz		Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	Re: Plan document updates
126	AZSTATE.100639	AZSTATE.100640	6/8/2016	Nicolette A Schultz	Marie Isaacson		Attorney-Client Communication	Re: fyi
127	AZSTATE.129503	AZSTATE.129504	1/31/2020	Scott Bender	Kimberly Suciu; Nicole Sornsin; Paul Shannon		Attorney-Client Communication	Fwd: Members' using Hormone Replacement Drug Therapy
128	AZSTATE.129505	AZSTATE.129507	1/13/2020	Paul Shannon	Nicole Sornsin; Kimberly Suciu		Attorney-Client Communication	Fwd: Harmful exclusions from state healthcare plan.
129	AZSTATE.129508	AZSTATE.129509	1/7/2020	Kimberly Suciu	Paul Shannon	Nicole Sornsin	Attorney-Client Communication	Re: Transgender benefits
130	AZSTATE.129510	AZSTATE.129510	1/7/2020	Paul Shannon	Kimberly Suciu		Attorney-Client Communication	Fwd: Transgender benefits
131	AZSTATE.129678	AZSTATE.129681	11/6/2019	Paul Shannon	Nicole Sornsin		Attorney-Client Communication	Re: Harmful exclusions from state healthcare plan.

State of Arizona Privilege/ Redaction Log

No.	*DocID/ Beg Bates No.*	*DocID/ End Bates No.*	*Date*	*From/ Author*	*To*	*CC*	*Privilege Type*	*Subject/ Description*
132	AZSTATE.129682	AZSTATE.129684	11/6/2019	Nicole Sornsin	Paul Shannon		Attorney-Client Communication	Re: Harmful exclusions from state healthcare plan.
133	AZSTATE.129685	AZSTATE.129687	11/6/2019	Paul Shannon	Nicole Sornsin		Attorney-Client Communication	Re: Harmful exclusions from state healthcare plan.
134	AZSTATE.129688	AZSTATE.129690	11/6/2019	Nicole Sornsin	Paul Shannon	Kimberly Suciu	Attorney-Client Communication	Re: Harmful exclusions from state healthcare plan.
135	AZSTATE.129691	AZSTATE.129693	11/6/2019	Paul Shannon	Nicole Sornsin; Kimberly Suciu		Attorney-Client Communication	Fwd: Harmful exclusions from state healthcare plan.
136	AZSTATE.129694	AZSTATE.129695	11/6/2019	Scott Bender	Paul Shannon		HIPAA/Personally Identifiable Information	Fwd: Harmful exclusions from state healthcare plan.
137	AZSTATE.129696	AZSTATE.129696	10/25/2019	Paul Shannon	Nicole Sornsin; Kimberly Suciu		Attorney-Client Communication	Fwd: Providers and payers get new court ruling on ACA protections for transgender patients
138	AZSTATE.129813	AZSTATE.129814	10/15/2018	Paul Shannon	John Fry		Attorney-Client Communication	Fwd: Interesting Governing article...
139	AZSTATE.129815	AZSTATE.129817	10/10/2018	Paul Shannon	Yvette Medina; Scott Bender		Attorney-Client Communication	Fwd: Request for documentation regarding ADOA's medical coverage
140	AZSTATE.129818	AZSTATE.129819	10/6/2018	John Fry	Paul Shannon		Attorney-Client Communication	RE: Request for documentation regarding ADOA's medical coverage
141	AZSTATE.129820	AZSTATE.129821	10/2/2018	Paul Shannon	John Fry		Attorney-Client Communication	Re: Request for documentation regarding ADOA's medical coverage
142	AZSTATE.129936	AZSTATE.129937	1/13/2020	Noah Munoz	Rose Bernal		HIPAA/Personally Identifiable Information	Fwd: Harmful exclusions from state healthcare plan.
143	AZSTATE.129942	AZSTATE.129942	11/6/2019	Noah Munoz	Scott Bender	Yvette Medina; Rose Bernal	HIPAA/Personally Identifiable Information	Fwd: Harmful exclusions from state healthcare plan.
144	AZSTATE.130286	AZSTATE.130286	8/23/2017	Staci Wilson	Rose Bernal	[REDACTED]	HIPAA/Personally Identifiable Information	Additional Information - Appeal
145	AZSTATE.130407	AZSTATE.130407	8/21/2017	[REDACTED]	Rose Bernal	Staci R. Wilson; Helena A. Rodrigues	HIPAA/Personally Identifiable Information	Appeal Denied
146	AZSTATE.130408	AZSTATE.130409	8/1/2017	Rose Bernal	Staci Wilson		HIPAA/Personally Identifiable Information	RE: Transgender coverage - hormone therapy
147	AZSTATE.130410	AZSTATE.130411	8/1/2017	Rose Bernal	Shannon Daniel	Scott Bender; Yvette Medina	HIPAA/Personally Identifiable Information	FW: Transgender coverage - hormone therapy
148	AZSTATE.136595	AZSTATE.136595	8/1/2017	Staci Wilson	Yvette Medina; Rose Bernal; Scott Bender		HIPAA/Personally Identifiable Information	Transgender coverage - hormone therapy
149	AZSTATE.136602	AZSTATE.136602	6/2/2017	Elizabeth Schafer			HIPAA/Personally Identifiable Information	Blue Cross Blue Shield of Arizona member Satisfaction Survey Results
150	AZSTATE.139839	AZSTATE.139839	4/22/2019	Peter Chiappa			HIPAA/Personally Identifiable Information	Report of ADOA transgender services from Aetna
151	AZSTATE.143577	AZSTATE.143581	1/25/2017				HIPAA/Personally Identifiable Information	Session Roster - 2017 Benefits Liaison Training
152	AZSTATE.143582	AZSTATE.143582	1/26/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
153	AZSTATE.151751	AZSTATE.151761	2/3/2020				Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	Various notes from Ms. Isaacson
154	AZSTATE.188313	AZSTATE.188313	3/27/2020				HIPAA/Personally Identifiable Information	UnitedHealthcare member Satisfaction Survey Results
155	AZSTATE.189467	AZSTATE.189467	4/6/2020				HIPAA/Personally Identifiable Information	UnitedHealthcare member Satisfaction Survey Results

State of Arizona Privilege/ Redaction Log

No.	*DocID/ Beg Bates No.*	*DocID/ End Bates No.*	*Date*	*From/ Author*	*To*	*CC*	*Privilege Type*	*Subject/ Description*
156	AZSTATE.190624	AZSTATE.190624	4/10/2020				HIPAA/Personally Identifiable Information	UnitedHealthcare member Satisfaction Survey Results
157	AZSTATE.207655	AZSTATE.207656	8/22/2017	Rose Bernal	Kayla Stivason		HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
158	AZSTATE.207657	AZSTATE.207659	8/22/2017	Kayla Stivason	Erin Russell	Scott Bender	HIPAA/Personally Identifiable Information	FW: Appeal Denied secure
159	AZSTATE.207660	AZSTATE.207662	8/22/2017	Kayla Stivason	Rose Bernal		HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
160	AZSTATE.207663	AZSTATE.207665	8/22/2017	Rose Bernal	Kayla Stivason		HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
161	AZSTATE.207666	AZSTATE.207668	8/22/2017	Kayla Stivason	Rose Bernal	Erin Russell; Scott Bender	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
162	AZSTATE.207669	AZSTATE.207672	8/22/2017	Rose Bernal	Kayla Stivason	Erin Russell; Scott Bender	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
163	AZSTATE.207673	AZSTATE.207676	8/22/2017	Erin Russell	Rose Bernal; Kayla Stivason	Scott Bender	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
164	AZSTATE.207677	AZSTATE.207684	8/25/2017	Scott Bender	Mary Cappabianco; Erin Russell; Kayla Stivason; Rose Bernal	Sean Kirwan	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
165	AZSTATE.207685	AZSTATE.207693	8/25/2017	Erin Russell	Scott Bender; Mary Cappabianco; Kayla Stivason; Rose Bernal	Sean Kirwan	HIPAA/Personally Identifiable Information	RE: Appeal Denied secure
166	AZSTATE.207722	AZSTATE.207724	2/3/2017	Stu Wilbur			Confidential, non-relevant information	Benefits Services Division - Meeting Agenda
167	AZSTATE.235593	AZSTATE.235597	10/29/2020	Rose Bernal	Rose Bernal; Amy Kenney-Hudson		HIPAA/Personally Identifiable Information	2020.10.29
168	EML00007556	EML00007557	10/6/2018	John Fry	Elizabeth Thorson		Attorney-Client Communication	Attorney-Client Privileged Communication
169	EML00012453	EML00012453	1/3/2017	Nicole Ong	Marie Isaacson		Attorney-Client Communication	Federal judge halts transgender protections in Obamacare
170	AZSTATE.246034	AZSTATE.246036	12/15/2016	Marie Isaacson	Christina Corieri	Scott Bender; Nicole Ong	Deliberative Process Privilege - **PRODUCED PURSUANT TO COURT ORDER**	RE: ACA §1557 Non-Discrimination

EXHIBIT 10

From: Curtis, Ryan <RCurtis@fennemorelaw.com>
Sent: Monday, May 10, 2021 9:27 PM
To: Wall, Jordan
Cc: Eckstein, Paul (Perkins Coie); Yost, Austin C. (Perkins Coie); Wendt, Clair (Perkins Coie); Nyberg, Gina (Perkins Coie); Cohan, Shannon; Abdo, Amy; Berg, Tim; 'Joshua Block'; 'Christine Wee'; Powell, Wesley; Freimuth, Matthew; Sheets, Victoria; Abdalla, Gabriela; Garbacz, Justin
Subject: Toomey v. Arizona - Attorney-Client Privilege [FC-Email.FID11439673]

*** EXTERNAL EMAIL ***

Jordan,

We are writing as follow up to our discussions last week about the attorney-client privilege and whether the privilege has been waived. During our call last week, I explained that State Defendants disagree that there has been any waiver of the privilege. There has been no affirmative defense asserted regarding advice of counsel in the State Defendants' Answer to the Amended Complaint or otherwise. The Response to the First Interrogatory addressed in your letter dated April 28, 2021, noted that ADOA made a decision and also noted that attorney-client communications are privileged. As noted in *Melendres v. Arpaio*, 2015 12911719 (D. Ariz. 2015) (citing *In Re Cnty. Of Erie*, 546 F.3d 222 (2d. Cir. 2008), "In general, disclosing legal counsel was consulted, the subject about which advice of [sic] received, or that action taken based on that advice, does not necessarily waive the privilege." In her deposition, Ms. Isaacson did not say what the legal advice was—only that it was obtained and a decision was made. Further, Ms. Isaacson did not and could not have waived the privilege during her deposition testimony on behalf of the State Defendants. When the client at issue is a corporation or other entity, only those in authority to speak for the entity can assert or waive the privilege. Actions to waive a privilege "must necessarily be undertaken by individuals empowered to act on behalf of the corporation." *Commodity Futures Trading Com'n v. Weintraub*, 471 U.S. 343 (1985). Ms. Isaacson had long since ceased to be an employee of the State when she was deposed. A former employee cannot waive the privilege on behalf of an entity. *Smith v. Ergo Sols*., LLC, 2017 WL 2656096, at *4 (D.D.C. June 20, 2017). The entity controls the attorney-client privilege. The entity asserts it and can waive it, but it must do so through someone with authority. *U.S. v. Graf*, 610 F.3d 1148 (9th Cir. 2010); *Creative Tent Int'l Inc. v. Kramer*, 2015 WL 4638320 (D. Ariz. 2015).

During our call last week, you also raised for the first time whether there was a waiver based on State Defendants' response to Interrogatory #7. That response notes that, among things considered by the State Defendants was a memorandum to Mike Liburdi, General Counsel at the Governor's Office dated August 3, 2016, regarding Affordable Care Act § 1557, and a Memorandum regarding non-discrimination and ACA § 1557 dated July 20, 2016 to Marie Isaacson from outside legal counsel. The response likewise notes that the documents are covered by the attorney-client privilege. This response is not a waiver, but an assertion of the privilege. You seemed to suggest that communication with the Governor's Office constituted a waiver in and of itself. We disagree. For many years, the attorney-client privilege has been extended to cover "common interest" situations. The "common interest" doctrine (also known as the "joint defense" doctrine) provides "an exception to ordinary waiver rules designed to allow attorneys for different clients pursuing a common legal strategy to communicate with each other." *In re Pac. Pictures Corp.*, 679 F.3d 1121, 1129 (9th Cir. 2012). The doctrine enables litigants who share unified interests to exchange privileged communications in order to adequately prepare their cases without losing the protection afforded the privilege. *Id.* The common interest privilege is not limited to "joint defense" situations "or even situations in which litigation has commenced." *See, e.g., U.S. v. Gonalq*, 559 F.3d 974, 978 (9th Cir. 2012) (holding that common interest agreement "may be implied from conduct and situation, such as attorneys exchanging confidential communications from clients who are or potentially

may be codefendants or have common interests in litigation"); *see also, e.g., id.* at 980 (noting that there is no requirement that parties asserting a common interest privilege be defendants in the same action, explaining that "parties in separate actions might nonetheless have reasons to work together toward a common objective, and there is no requirement that actual litigation even be in progress"). Moreover, the "common interests" to which the privilege extends are not limited to "legal" interests, but may also be "factual or strategic in character." *See* RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 76, cmt. e; *see also, e.g., Hunydee v. U.S.*, 355 F.2d 183, 185 (9th Cir. 1965) (affirming that communications may be protected by the common interest privilege, "even though exchanged between attorneys . . . to the extent they concern common issues and are intended to facilitate representation in possible subsequent proceedings"). Because the need to protect the free flow of information from client to attorney logically exists whenever multiple parties share a common interest about a legal matter, courts have extended the joint defense or common interest doctrine to numerous relationships among different parties. *In re Grand Jury Subpoenas, 89-3 & 89-4, John Doe 89-129*, 902 F.2d 244, 249 (4th Cir. 1990). This includes parties to *potential* litigation. *Gonalq*, 559 F.3d at 980 ("there is no requirement that actual litigation even be in progress"); *see also United States v. Schwimmer*, 892 F.2d 237, 243–44 (2d Cir. 1989) ("it is therefore unnecessary that there be actual litigation in progress for the common interest rule of the attorney-client privilege to apply") .

In this case, it is obvious that ADOA and the Governor's Office have a common legal interest regarding the terms of the health plan. Both could have been named as defendants in litigation potentially to enforce ACA § 1557 or in litigation based on Title VII or Equal Protection claims. Indeed, it has been Plaintiff's position that both ADOA and the Governor's Office are subparts of the State of Arizona equally responsible to Plaintiff and the certified classes for the claims at issue. Further, while not a party to this litigation, Plaintiff has certainly involved the Governor's Office via subpoena, the deposition of Christina Corieri, and its own disputes over discovery directly with the Governor's Office. Certainly at the time the State Defendants considered the information described in the Response to Interrogatory #7, the State Defendants and the Governor's Office had a common interest in potential litigation against them. This was also made clear months ago in the State Defendants' responses to various other interrogatories from Plaintiff.

Ryan C. Curtis, Chair - ERISA & Employee Benefits Practice Group

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Fennemore has expanded to California. Read more here.

EXHIBIT 11

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May 14, 2021

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Re: *Toomey v. State of Arizona, et al.*
Responses and Objections to State Defendants' Discovery Requests

Dear Counsel:

We are writing regarding Plaintiff's April 14, 2021, responses and objections to State Defendants' First Set of Interrogatories and First Set of Requests for Production.

Interrogatory Objections

State Defendants' single interrogatory asked Plaintiff to describe in detail any facts supporting that the Exclusion was created and/or maintained for a discriminatory purpose, and to identify all documents and witnesses who support that the Exclusion was created and/or maintained for a discriminatory purpose. Plaintiff objected to the interrogatory as a premature contention interrogatory. Curiously, Plaintiff cited to Federal Rule of Civil Procedure 33(a)(2), which specifically states that "An interrogatory is not objectionable merely because it asks for an opinion or contention that relates to fact or the application of law to fact." It further states that a "court *may* order that the interrogatory need not be answered until designated discovery is complete, or until a pretrial conference or some other time." (emphasis added).

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There is no such order in place that justifies Plaintiff's refusal to answer this interrogatory. The case Plaintiff cited to justify its nonresponse explains that generally, such interrogatories need not be answered until discovery is substantially complete. *Core Optical Techs. v. Infinera Corp.*, No. SACV170548AGJPRX, 2018 WL 2684693, at *2 (C.D. Cal. Mar. 7, 2018). However, the court in *Core Optical* still ordered the objecting party to respond to the interrogatory to the best of its ability and to supplement its responses no later than when discovery is substantially complete. *Id.* The objecting party was "equipped to meaningfully respond" based on the discovery that had already occurred. Plaintiff has received numerous documents, discovery responses from State Defendants and ABOR, and has conducted six depositions (nearly all of which were in excess of seven hours including ABOR's questions). Plaintiff is meaningfully equipped to respond to the interrogatory now. If Plaintiff learns of additional grounds during later discovery, Plaintiff may certainly supplement his response. Without an order from the Court that the interrogatory need not be answered, Plaintiff is in violation of Rule 33.

We would be pleased to discuss this with you in the next few days, however, we anticipate that if Plaintiff will not agree to promptly and fully respond to Interrogatory #1, State Defendants will address this through a motion to the Court. Plaintiff cannot simply refuse to respond entirely based on the assertion the interrogatory is a premature contention interrogatory.

Requests for Production

RFP #1:

This request seeks all documents and communications evidencing the harm allegedly suffered by Plaintiff as a result of the Exclusion. Plaintiff declined to produce anything on the basis that Plaintiff is not seeking damages but only injunctive relief and that accordingly, evidence of Plaintiff's harm is irrelevant to any party's claim. The request makes no reference to damages or compensation for some loss or injury. It only references the actual harm—Dr. Toomey's injury, loss, or detriment. Plaintiff cannot refuse to produce documents about harm by unilaterally construing the request as referring to monetary damages rather than the harm for which Dr. Toomey seeks injunctive relief.

Plaintiff also suggests providing any evidence of harm is not necessary because the medical necessity of Dr. Toomey's individual care is not an issue in this case. Plaintiff asserts this because of the Parties' agreement to limit the scope of discovery regarding medical necessity. Specifically, the parties narrowed the issues by agreeing that medical necessity of gender affirming surgery will not be an issue. (Doc. #128 at 11:10-20). But that is wholly unrelated to harm. Request for Production #1 does not address medical necessity of any surgery—it only addresses evidence of Dr. Toomey's harm.

Plaintiff's objections are without merit. Plaintiff must produce documents and communications evidencing harm Plaintiff allegedly suffered due to the Exclusion. If Plaintiff does not claim to have suffered any harm, Plaintiff may so state in response. Likewise, if Plaintiff does not intend to offer any evidence of harm, Plaintiff may state that as well.

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RFP #3:

This request seeks all communications between Plaintiff and any insurance company and/or representative relating to the Exclusion or any healthcare which was denied as a result of the Exclusion. Plaintiff objected and suggests Dr. Toomey has already produced all documents within his custody and control. This response is plainly inadequate as Plaintiff failed to produce any communications between himself and Blue Cross Blue Shield of Arizona ("BCBS") relating to Plaintiff's request for a hysterectomy, BCBS's denial of such request, or the Exclusion.[1] Plaintiff is obligated to produce documents responsive to Request For Production #3.

RFP #5:

This request seeks all documents and communications authored by Dr. Toomey regarding being transgender, transgender health care, transgender discrimination, transgender health care Dr. Toomey has sought and/or received to treat his gender dysphoria, the Plan, the Exclusion, and the denial of his request for gender reassignment surgery. Plaintiff objected to the request as irrelevant and produced nothing, but acknowledged that Dr. Toomey writes extensively about the topics as part of his academic work.

This request is relevant to harm Dr. Toomey allegedly experiences. Additionally, Plaintiff has repeatedly referred to standards of care issued by the World Professional Association for Transgender Health (WPATH), addressed what is commonly accepted in the healthcare as treatments, and argued that Plaintiff and similarly-situated persons are being denied medically necessary care. Dr. Toomey's writings, as a university professor and Plaintiff in this case, are directly relevant to the extent they directly or indirectly address any of these topics. Plaintiff cannot simply make assertions about standards of care, discrimination transgender individuals experience as a class, and the medical necessity and standards of care for gender dysphoria and expect that they be accepted as true facts if anything he has written professionally or on social media contradicts or otherwise implicates such issues.

We find Plaintiff's assertions that producing these items is overly burdensome not to be credible. Dr. Toomey's profile page with the University of Arizona lists numerous publications.[2] Certainly, if Dr. Toomey needed to obtain these for a professional engagement or opportunity, he could access them. He is seeking relief through the Court and has made affirmative claims against the State and ABOR to provide the coverage he seeks, which comes with the obligation to produce relevant documents. Claims that this is burdensome are also very hollow considering how many documents the State Defendants have reviewed and produced at significant cost and consulted with Plaintiff counsel

[1] Since Plaintiff served its responses and objections, BCBS responded to a subpoena duces tecum issued by the State Defendants and provided responsive documents which include communications with Plaintiff. However, this production does not satisfy Plaintiff's independent obligation to produce all documents in his possession, custody, and control.

[2] *See* https://cals.arizona.edu/fcs/faculty/russell_toomey, last accessed May 14, 2021.

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on numerous occasions to come to compromises for additional searches. The documents and information requested are relevant and proportional to the needs of the case and must be produced.

If you are unwilling to comply with the above requests, let us know your availability for a meet and confer on these issues or on any other matters. This letter is not necessarily a comprehensive summary of State Defendant's issues with Plaintiff's responses and objections to the Interrogatory and Requests for Production, and the State Defendants reserve their right to raise additional deficiencies with Plaintiff's responses. Further, and as you know, we have tentatively scheduled Dr. Toomey's deposition for May 26, 2021. We will need these discovery responses ahead of that deposition with adequate time to review them. Otherwise, we will need to reschedule Dr. Toomey's deposition. Accordingly, please let us know by close of business Monday if Plaintiff will serve supplemental interrogatory responses and produce the documents discussed herein by May 24.

Sincerely,

FENNEMORE CRAIG, P.C.

Ryan C. Curtis

cc: Paul F. Eckstein
Austin C. Yost
Perkins Coie, LLP
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peckstein@perkinscoie.com
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18419670

EXHIBIT 12

From: Curtis, Ryan <RCurtis@fennemorelaw.com>
Sent: Friday, May 14, 2021 8:19 PM
To: Wall, Jordan <JWall@willkie.com>
Cc: Eckstein, Paul (Perkins Coie) <PEckstein@perkinscoie.com>; Yost, Austin C. (Perkins Coie) <AYost@perkinscoie.com>; Wendt, Clair (Perkins Coie) <CWendt@perkinscoie.com>; Nyberg, Gina (Perkins Coie) <GNyberg@perkinscoie.com>; Cohan, Shannon <scohan@fennemorelaw.com>; Abdo, Amy <amy@fennemorelaw.com>; Berg, Tim <TBerg@fennemorelaw.com>; 'Joshua Block' <jblock@aclu.org>; 'Christine Wee' <CWee@acluaz.org>; Powell, Wesley <wpowell@willkie.com>; Freimuth, Matthew <mfreimuth@willkie.com>; Sheets, Victoria <VSheets@willkie.com>; Abdalla, Gabriela <GAbdalla@willkie.com>; Garbacz, Justin <JGarbacz@willkie.com>
Subject: RE: Toomey v. Arizona - Attorney-Client Privilege [FC-Email.FID11439673]

*** EXTERNAL EMAIL ***

Jordan,

Please see the attached letter regarding Plaintiff's responses and objections to State Defendants' prior discovery requests.

Regarding deposition scheduling, Paul Shannon can be available for a deposition on June 18 or 25.

We can take Joan Barrett's deposition on June 24. Please let us know if this works for everyone.

If you have confirmed logistics for how you would like to proceed with Craig Brown's deposition considering his residence in Montana, I can obtain dates for him. As I mentioned last week, he resides in Flathead County, MT, but indicated that he resides about 30 minutes outside of Kalispell, MT, which is the county seat.

Finally, we would be pleased to further discuss in a meet and confer the attorney-client privilege matter addressed below. We did not discuss the issue of any waiver related to State Defendant's interrogatory response #7 related to the Governor's Office as you raised that for the first time during our last meet and confer. We would be interested in discussing on what basis you disagree with the arguments and cases noted in my email below from May 10.

Ryan C. Curtis, Chair - ERISA & Employee Benefits Practice Group
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From: Wall, Jordan <JWall@willkie.com>
Sent: Friday, May 14, 2021 3:38 PM
To: Curtis, Ryan <RCurtis@fennemorelaw.com>
Cc: Eckstein, Paul (Perkins Coie) <PEckstein@perkinscoie.com>; Yost, Austin C. (Perkins Coie) <AYost@perkinscoie.com>; Wendt, Clair (Perkins Coie) <CWendt@perkinscoie.com>; Nyberg, Gina (Perkins Coie) <GNyberg@perkinscoie.com>; Cohan, Shannon <scohan@fennemorelaw.com>; Abdo, Amy <amy@fennemorelaw.com>; Berg, Tim <TBerg@fennemorelaw.com>; 'Joshua Block' <jblock@aclu.org>; 'Christine Wee' <CWee@acluaz.org>; Powell, Wesley <wpowell@willkie.com>; Freimuth, Matthew <mfreimuth@willkie.com>; Sheets, Victoria <VSheets@willkie.com>; Abdalla, Gabriela <GAbdalla@willkie.com>; Garbacz, Justin <JGarbacz@willkie.com>
Subject: RE: Toomey v. Arizona - Attorney-Client Privilege [FC-Email.FID11439673]

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Subject: Toomey v. Arizona - Attorney-Client Privilege [FC-Email.FID11439673]

*** EXTERNAL EMAIL ***

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Ryan C. Curtis, Chair - ERISA & Employee Benefits Practice Group

FENNEMORE.

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Fennemore has expanded to California. Read more here.

CONFIDENTIALITY NOTICE: The information contained in this message may be protected by the attorney-client privilege. If you believe that it has been sent to you in error, do not read it. Please immediately reply to the sender that you have received the message in error. Then delete it. Thank you.

COVID-19: Governors in our markets have deemed law firms essential services. As a result, our offices will be open from 8 am to 5 pm, but most of our team members are working remotely. To better protect our employees and clients, please schedule an appointment before coming to our offices.

EXHIBIT 13

From: Wall, Jordan <JWall@willkie.com>
Sent: Monday, May 17, 2021 1:19 PM
To: 'Curtis, Ryan'
Cc: Eckstein, Paul (Perkins Coie); Yost, Austin C. (Perkins Coie); Wendt, Clair (Perkins Coie); Nyberg, Gina (Perkins Coie); Cohan, Shannon; Abdo, Amy; Berg, Tim; 'Joshua Block'; 'Christine Wee'; Powell, Wesley; Freimuth, Matthew; Sheets, Victoria; Abdalla, Gabriela; Garbacz, Justin
Subject: RE: Toomey v. Arizona - Attorney-Client Privilege [FC-Email.FID11439673]

Ryan,

We have reviewed your letter of May 14, and have at least partial thoughts on some of the issues raised therein. Although we have not heard back from you regarding the below, we propose a comprehensive meet-and-confer tomorrow to address parts of that May 14 letter, as well as the below. 2:00 PM NY / 11:00 AM Arizona would work on our end.

Thanks,
Jordan

Jordan C. Wall
Willkie Farr & Gallagher LLP
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Direct: +1 212 728 8465 | Fax: +1 212 728 9465
jwall@willkie.com | vCard | www.willkie.com bio
Pronouns: he, him, his

From: Wall, Jordan <JWall@willkie.com>
Sent: Saturday, May 15, 2021 1:27 PM
To: 'Curtis, Ryan' <RCurtis@fennemorelaw.com>
Cc: Eckstein, Paul (Perkins Coie) <PEckstein@perkinscoie.com>; Yost, Austin C. (Perkins Coie) <AYost@perkinscoie.com>; Wendt, Clair (Perkins Coie) <CWendt@perkinscoie.com>; Nyberg, Gina (Perkins Coie) <GNyberg@perkinscoie.com>; Cohan, Shannon <scohan@fennemorelaw.com>; Abdo, Amy <amy@fennemorelaw.com>; Berg, Tim <TBerg@fennemorelaw.com>; 'Joshua Block' <jblock@aclu.org>; 'Christine Wee' <CWee@acluaz.org>; Powell, Wesley <wpowell@willkie.com>; Freimuth, Matthew <mfreimuth@willkie.com>; Sheets, Victoria <VSheets@willkie.com>; Abdalla, Gabriela <GAbdalla@willkie.com>; Garbacz, Justin <JGarbacz@willkie.com>
Subject: RE: Toomey v. Arizona - Attorney-Client Privilege [FC-Email.FID11439673]

Ryan,

Thank you for the correspondence. We did not receive your letter until after the close of business on Friday, May 14, Arizona time, and our late evening. Your demand for a response by close of business Monday, May 15, does not allow us time to meaningfully review or consider the arguments raised in your letter. We will therefore respond once we have had a reasonable time to review and discuss.

We will let you know about those dates for Mr. Shannon and Mr. Craig's respective depositions. As for Ms. Barrett, as previously requested, please provide us with a few dates when State Defendants are available to take this deposition as we must consider both her and our own schedules. We will discuss whether the 24th will work in the meantime.

With respect to the waiver argument, we articulated our reasons for believing a waiver has occurred during the parties' meet and confer, which you then asked for time to consider. You have now addressed each of the specific arguments we raised for your consideration in your response below, and disagreed with us on every point. We therefore think this issue is fully developed, and that the parties have personally consulted and made a sincere effort to resolve this dispute, but to no avail.

We are available to further meet and confer about this specific waiver argument on Monday, May 15th however if State Defendants sincerely believe the parties may be able to resolve this dispute. As noted in our discussions about the discovery schedule, time is of the essence here given the relatively short extension of the discovery deadlines, the time it may take to fully brief this matter before the court if necessary, and the potential impact of this dispute on the scheduled depositions. We will not agree to further delay submission of this dispute to the court beyond a meet and confer on Monday absent agreement for expediting any briefing, if motion practice remains necessary.

Thanks,
Jordan

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Jordan,

Please see the attached letter regarding Plaintiff's responses and objections to State Defendants' prior discovery requests.

Regarding deposition scheduling, Paul Shannon can be available for a deposition on June 18 or 25.

We can take Joan Barrett's deposition on June 24. Please let us know if this works for everyone.

If you have confirmed logistics for how you would like to proceed with Craig Brown's deposition considering his residence in Montana, I can obtain dates for him. As I mentioned last week, he resides in Flathead County, MT, but indicated that he resides about 30 minutes outside of Kalispell, MT, which is the county seat.

Finally, we would be pleased to further discuss in a meet and confer the attorney-client privilege matter addressed below. We did not discuss the issue of any waiver related to State Defendant's interrogatory response #7 related to the Governor's Office as you raised that for the first time during our last meet and confer. We would be interested in discussing on what basis you disagree with the arguments and cases noted in my email below from May 10.

Ryan C. Curtis, Chair - ERISA & Employee Benefits Practice Group
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UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. **State of Arizona; Arizona Board of Regents, D/B/A University of Arizona**, a governmental body of the State of Arizona; et al., Defendants.	Case No.19-cv-00035-TUC-RM (LAB) **[PROPOSED] ORDER**

The Court having reviewed Plaintiff Russell B. Toomey's Motion Compelling Production of Documents (Doc. _____) and finding good cause,

IT IS ORDERED:

1. Plaintiff's Motion is GRANTED.

2. State of Arizona, Andy Tobin, and Paul Shannon ("State Defendants") are hereby compelled to produce all the documents currently withheld on the basis of attorney-client privilege with respect to legal advice they received on the legality of the Exclusion as State Defendants have waived this privilege.

3. State Defendants shall produce the documents above within 14 days of the date of this Order.

Dated this _____day of _____, 2021.

Leslie A. Bowman
United States Magistrate Judge

EXHIBIT 4

FENNEMORE CRAIG, P.C.
Timothy J. Berg (No. 004170)
Amy Abdo (No. 016346)
Ryan Curtis (No. 025133)
Shannon Cohan (No. 034429)
2394 E. Camelback Road
Suite 600
Phoenix, Arizona 85016
Telephone: (602) 916-5000
Email: tberg@fennemorelaw.com
Email: amy@fennemorelaw.com
Email: rcurtis@fennemorelaw.com
Email: scohan@fennemorelaw.com

Attorneys for Defendants State of Arizona, Andy Tobin, and Paul Shannon

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. State of Arizona, *et al.*, Defendants.	Case No. CV 19-0035-TUC-RM (LAB) **STATE DEFENDANTS' RESPONSES TO PLAINTIFF'S FIRST REQUEST FOR PRODUCTION OF DOCUMENTS AND TANGIBLE THINGS**

Pursuant to Rules of Civil Procedure 26 and 34, Defendants State of Arizona, Andy Tobin, and Paul Shannon (hereinafter the "State Defendants") hereby respond to Plaintiff's First Request For Production of Documents And Tangible Things, served December 8, 2020, as follows:

PRELIMINARY STATEMENT

The State Defendants have not fully completed their investigation of the facts relating to this case, discovery is underway, and the State Defendants have not begun preparing for trial. All answers contained herein are based only upon the information presently available to and specifically known by the State Defendants and they disclose only those conclusions and contentions which presently occur to them. Further investigation, legal research and analysis may supply additional facts, add meaning to the

known facts, and may establish entirely new factual conclusions and legal contentions, all of which may lend substantial additions to, changes, and variations from the responses herein set forth.

The following answers are given without prejudice to or waiver of the State Defendants' right to introduce evidence of subsequently discovered and developed conclusions or contentions. The answers contained herein are made in a good faith effort to supply as much factual information and as much specification of legal contentions as is presently known, but in no way should be to the prejudice of the State Defendants in relation to discovery, research or analysis. The State Defendants specifically reserve the right to supplement, amend and/or modify any or all of the answers contained herein as discovery progresses.

GENERAL OBJECTIONS

1. These responses are made solely for the purpose of and use in this litigation. Each response is given subject to all appropriate objections (including, but not limited to, objections concerning relevancy, materiality, propriety, and admissibility) that would require the exclusion of any statement contained herein if the request were asked of, or any statement contained herein were made by, a witness testifying in court. The State Defendants reserve all such objections and grounds therefor and may interpose them at the time of trial.

2. The State Defendants object to this discovery to the extent it seeks information other than that which may be obtained through a reasonably diligent search of their records.

3. The State Defendants object to this discovery as overbroad, unduly burdensome, oppressive, harassing, and seek to impose unreasonable costs on the State Defendants to the extent that it purports to require the State Defendants to conduct a search of all of their files, including all of their electronic files, or to inquire of all their employees, in an attempt to locate each piece of information or every document that might be

responsive. The State Defendants further object to this discovery to the extent that the scope of information requested is not proportional to the needs of the case.

4. The State Defendants object to this discovery to the extent it seeks information protected by the attorney-client privilege, the "work-product" doctrine, the doctor-patient privilege, the deliberative process privilege, and/or any other applicable protection or privilege. The inadvertent production of any privileged information is not a waiver of the State Defendants' rights to assert any applicable privilege with respect to such information.

5. The State Defendants object to this discovery to the extent it is vague, ambiguous, and unintelligible and requires the State Defendants to speculate as to the nature and scope of the information sought.

6. The State Defendants object to this discovery to the extent it seeks information that is in the public domain and/or to which Plaintiff has equal or greater access.

7. The State Defendants object to this discovery to the extent it seeks information which is neither relevant nor reasonably related to any claim or defense or is otherwise beyond the scope of discovery contemplated by the Federal Rules of Civil Procedure.

8. The State Defendants object to this discovery to the extent it seeks documents or information not in their possession, custody, or control. In particular, State Defendants are producing document in the custody and control of the Arizona Department of Administration. Therefore, documents that may be in the custody and control of the Arizona Governor's Office, the Arizona Attorney General's Office, or the Arizona Legislature are not being produced.

9. The State Defendants object to this discovery to the extent it seeks information, the production of which would violate any constitutional, statutory or common law privacy interest of any representative of the State Defendants or any other person or entity, including, but not limited to, beneficiaries of the Plan.

10. The State Defendants object to this discovery to the extent that the definition of "Defendants" includes the Office of the Arizona Governor (whether past or present) and the Arizona Legislature.

These General Objections are hereby incorporated and made a part of each and every response to the requests set forth below.

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 1: Please produce all documents related to the Plan's current or prior Transgender Healthcare Exclusion, including, but not limited to

(a) all drafts and previous versions of the Transgender Healthcare Exclusion, including the earliest iteration of the Transgender Healthcare Exclusion, and any amendments or supplements thereto (whether actual or proposed);

(b) all documents (to include any formal or informal financial or budgetary or other analyses, actuarial reports, or other reports or memoranda) and communications between Defendants and all internal and external persons (including, but not limited to, any insurance company, any consultant, the Alliance Defending Freedom, the Center for Arizona Policy, or any lobbying or interest group regarding whether any form of transition-related care or the Transgender Health Exclusion should be adopted, modified, retained, or eliminated, and the rationale provided or discussed.

(c) all documents and communications with internal and external persons pertaining to Defendants' initial decision to exclude transition-related care, as well as any subsequent decisions to adopt, amend, retain, or eliminate any form of transition-related care or the Transgender Health Exclusion, including minutes or recordings of meetings where coverage for or exclusion of any form of transition-related care was discussed.

RESPONSE TO REQUEST FOR PRODUCTION NO. 1: The State Defendants object to Request For Production No. 1 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the scope of the Request is not proportional to the needs

of the case. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

The State Defendants will produce non-privileged documents responsive to Request For Production No. 1 in the possession, custody, and control of the Arizona Department of Administration. The State Defendants are not in possession, custody, or control of any Health Plan documents prior to 2005.

REQUEST FOR PRODUCTION NO. 2: Please produce all documents and communications between Defendants and internal and external persons relating to and regarding the State of Arizona's decision to join the litigation in the Northern District of Texas bearing Case No. 7:16-cv-00108 (originally filed as *Franciscan Alliance, Inc. et al. v. Burwell et al.*, later re-designated as *Franciscan Alliance, Inc. et al. v. Price et al.* and *Franciscan Alliance, Inc. et al. v. Azar II et al.*), and the State of Arizona's participation in that litigation.

RESPONSE TO REQUEST FOR PRODUCTION NO. 2: The State Defendants object to Request For Production No. 2 on the ground that it seeks information which is neither relevant nor reasonably related to any claim or defense in this matter. Any decision made to participate in the aforementioned litigation is irrelevant to the matters at issue in this case. The State Defendants further object that the Request is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks documents and communications

protected by the attorney-client privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. Moreover, the State Defendants further object that the Request seeks documents not in the possession, custody, or control of the Arizona Department of Administration because such decisions are not made by the Arizona Department of Administration, Defendants Andy Tobin or Paul Shannon in their official capacities, or their predecessors. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

The State Defendants will produce non-privileged documents responsive to Request For Production No. 2 in the possession, custody, and control of the Arizona Department of Administration.

REQUEST FOR PRODUCTION NO. 3: Please produce all versions and iterations of the Plan's policies/lists of Exclusions and General Limitations (*e.g.*, Article 9.1 of ADOA's PPO and EPO Plans, Article 10.1 of ADOA's HSA Plan) from the years 2010 through present, as well as all documents and communications between Defendants and internal or external persons regarding creating, amending, continuing, or eliminating any exclusion of coverage contained in any version/iteration of the Plan's Exclusions and General Limitations policy, including, but not limited to, the potential costs of enforcing, amending, or eliminating such excluded coverage, the medical necessity, safety, and efficacy (including whether a procedure is deemed experimental or cosmetic) of excluded treatments and services; or the public health effects of enforcing, amending, or eliminating such excluded coverage. Such documents should include any and all actuarial reports, analyses, or memorandums pertaining to such exclusions of coverage.

RESPONSE TO REQUEST FOR PRODUCTION NO. 3: The State Defendants object to Request For Production No. 3 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request is vague and ambiguous as to the term "medical necessity." The State Defendants further object that the Request is not

proportional to the needs of the case. The State Defendants further object that the Request seeks information which is duplicative of Request For Production No. 1. The State Defendants further object that the Request seeks information which is neither relevant nor reasonably related to any claim or defense in this matter. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory, and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

The State Defendants will produce copies of the Health Plans from 2010 to present.

REQUEST FOR PRODUCTION NO. 4: Please produce all documents and communications between the Defendants and internal or external persons regarding whether any treatment of gender dysphoria is "Medically Necessary."

RESPONSE TO REQUEST FOR PRODUCTION NO. 4: The State Defendants object to Request For Production No. 4 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request is vague and ambiguous as to the term "medically necessary." The State Defendants further object that the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks information which is neither relevant nor reasonably related to any claim or defense in this matter. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the doctor-patient privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the

constitutional, statutory, and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration. Finally, the State Defendants further object because the Parties already agreed, as set forth in the Joint Status Report to the Court on October 23, 2020 (Doc. 128), to narrow this case by agreeing that the medical necessity of gender transition surgeries will not be an issue in this case. *See* Doc. 128 at 11:11-20.

REQUEST FOR PRODUCTION NO. 5: Please produce all documents and communications between the Defendants and internal or external persons concerning (a) transgender people, (b) gender transition, (c) change of sex, (d) sex reassignment, (e) transsexualism; or (f) gender reassignment.

RESPONSE TO REQUEST FOR PRODUCTION NO. 5: The State Defendants object to Request For Production No. 5 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the doctor-patient privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory, and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration.

REQUEST FOR PRODUCTION NO. 6: Please produce documents sufficient to show, from 2010 to present:

(a) the number of hysterectomies paid for by the Plan each year, the medical reason for the surgery, and the individual and aggregate cost of the surgeries; and

(b) the number of medically necessary cosmetic or reconstructive surgical

procedures paid for by the Plan each year (including but not limited to chest-reconstruction surgery, vaginoplasty, or phalloplasty, or other surgery related to the reproductive or urogenital system) the medical reason for the surgery, and the individual and aggregate cost of the surgeries.

RESPONSE TO REQUEST FOR PRODUCTION NO. 6: The State Defendants object to Request For Production No. 6 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request is vague and ambiguous as to the terms "medically necessary," "cosmetic," and "reconstructive" procedures. The State Defendants further object that the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks information which is neither relevant nor reasonably related to any claim or defense in this matter to the extent it is seeking information regarding medical treatment and/or services other than for gender transition surgery. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the doctor-patient privilege, the work product doctrine, the deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory, and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration.

REQUEST FOR PRODUCTION NO. 7: Please produce all documents (to include any formal or informal financial or budgetary or other analyses, plans, actuarial reports, or other reports or memoranda) to show (1) the total annual expenses (*i.e.*, the amounts paid by the Plan to medical providers) for all treatment and services provided under the Plan from 2010 to present, including a cost breakdown of the total expenses for each type of treatment or service; and (2) the total annual amounts paid by the Defendants to pay for the Plan for all Plan recipients from 2010 to present, including an itemized breakdown of the total amounts

paid to the extent possible, and (3) budget projections and actuarial analyses of the Plan's fiscal soundness.

RESPONSE TO REQUEST FOR PRODUCTION NO. 7: The State Defendants object to Request For Production No. 7 on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request is vague as to the term "fiscal soundness." The State Defendants further object that the Request is not proportional to the needs of the case. The State Defendants further object that the Request seeks information which is neither relevant nor reasonably related to any claim or defense in this matter to the extent it is seeking information regarding medical treatment and/or services other than for gender transition surgery. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the doctor-patient privilege, the work product doctrine, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory, and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

The State Defendants do not have possession, custody, or control of responsive documents prior to 2013. The State Defendants will produce non-privileged documents responsive to Request For Production No. 7 in the possession, custody, and control of the Arizona Department of Administration.

REQUEST FOR PRODUCTION NO. 8: All documents or communications you intend to rely on at trial.

RESPONSE TO REQUEST FOR PRODUCTION NO. 8: The State Defendants object to Request for Production No. 8 on the ground that it is not yet the time for identifying the State Defendants' exhibits for trial and discovery is still ongoing. Subject to and without

waiving the foregoing objections, the State Defendants respond as follows:

The State Defendants have already produced documents responsive to Request For Production No. 8 in the possession, custody, and control of the Arizona Department of Administration. The State Defendants reserve the right to supplement this response as discovery progresses.

REQUEST FOR PRODUCTION NO. 9: Please produce all documents supporting Your responses to Plaintiff's First Set of Interrogatories provided to Defendants on June 5, 2020.

RESPONSE TO REQUEST FOR PRODUCTION NO. 9: The State Defendants object that Request For Production No. 9 is vague and ambiguous as to what documents "support" the State Defendants' responses. The State Defendants further object to the Request on the ground that it is overbroad, unduly burdensome, oppressive, harassing, and seeks to impose unreasonable costs on the State Defendants. The State Defendants further object that the Request seeks documents and communications protected by the attorney-client privilege, the doctor-patient privilege, the work product doctrine, deliberative process privilege, and other applicable privileges. The State Defendants further object that the Request seeks information protected by the constitutional, statutory, and/or common law privacy rights of the Plan beneficiaries. The State Defendants further object to the Request to the extent that it seeks documents not within the possession, custody, and control of the Arizona Department of Administration. Subject to and without waiving the foregoing objections, the State Defendants respond as follows:

The State Defendants have already produced non-privileged documents responsive to Request For Production No. 9 in the possession, custody, and control of the Arizona Department of Administration.

DATED this 21st day of January 2021.

FENNEMORE CRAIG, P.C.

By: *s/ Ryan Curtis*
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EXHIBIT 5

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona, *et al.*

Defendants.

No. 4:19-cv-00035

DEFENDANTS STATE OF ARIZONA'S, ANDY TOBIN'S, AND PAUL SHANNON'S OPPOSITION TO PLAINTIFF'S (SECOND) MOTION TO COMPEL

Defendants State of Arizona, Andy Tobin, and Paul Shannon (collectively, the "State Defendants") hereby oppose Plaintiff Russell B. Toomey's Motion to Compel the production of documents withheld under the attorney-client privilege (the "Motion"), filed May 20, 2021.

Plaintiff's Motion misconstrues the facts and law regarding the attorney-client privilege and waiver, and is wholly inaccurate regarding the nature of communications at issue and the relationship between the Arizona Department of Administration ("ADOA") and the Governor's Office. The State Defendants have not waived the privilege—intentionally or unintentionally. Plaintiff incorrectly argues the State Defendants asserted an advice of counsel defense through interrogatory responses and deposition testimony. A proper reading of the interrogatory responses shows there was no such assertion of a defense of advice of legal counsel. Alternatively, Plaintiff argues the State Defendants waived the privilege by disclosing the content of legal advice through the deposition testimony of a *former* ADOA employee or through disclosures to the Governor's Office. Plaintiff fails to recognize the powers and duties of Arizona's Governor under Arizona's Constitution and state law. ADOA and the Governor's Office easily meet the requirements of the common interest doctrine that expands the scope of the attorney-client privilege.

The attorney-client privilege is important for all clients but is critical for governmental entities to seek legal advice without fear of consequences or the apprehension of disclosure. However, Plaintiff's argument puts the State Defendants in a no-win situation. Plaintiff suggests that because the State Defendants acknowledge they wanted to follow the law, obtained legal advice, and made a decision addressing new non-discrimination rules issued in 2016 under the Affordable Care Act ("ACA") § 1557,[1] that the State Defendants broadly waived the attorney-client privilege. However, had the State Defendants *not* sought

[1] ACA § 1557 is codified at 42 U.S.C. § 18116.

legal advice about those new rules, Plaintiff certainly would be condemning them for failing to do so. Under Plaintiff's arguments, the State Defendants are damned if they do and damned if they don't. The effect of such reasoning is that government officials will be discouraged from seeking legal counsel, which undermines good public policy and the purpose of the attorney-client privilege.

The attorney-client privilege is not overcome. The Court should deny the Motion.

I. THE COURT SHOULD DENY PLAINTIFF'S MOTION TO COMPEL.

Parties may obtain discovery about any *nonprivileged* matter. Fed. R. Civ. P. 26(b)(1). Nothing in the Federal Rules of Civil Procedure authorizes a party to demand the production of privileged documents, but that is what Plaintiff seeks. A party may move the Court for an order compelling disclosure or discovery. Fed. R. Civ. Pro. 37. The burden falls on the moving party to demonstrate the non-moving party's objection is unjustified. *Ocean Garden Prod. Inc. v. Blessings Inc.*, No. CV-18-00322-TUC-RM, 2020 WL 4284383, at *2 (D. Ariz. July 27, 2020). As the moving party, Plaintiff further bears the burden of identifying (i) the specific documents that are the subject of his motion and (ii) why the State Defendants' assertions of privilege as to those documents are not justified. *See, e.g.*, *Hawkins v. Winkfield*, 219CV1228TLNKJNP, 2021 WL 1193421, *1–2 (E.D. Cal. March 30, 2021). Plaintiff fails in both regards. Plaintiff's Motion does not identify the specific documents at issue. *See id.* ("generalized identification" of the discovery requests is insufficient). And Plaintiff fails to demonstrate that there has been any waiver of the attorney-client privilege. Moreover, the State Defendants demonstrate herein that they have not waived the privilege.

A. The Attorney-Client Privilege.

"The attorney–client privilege is the oldest of the privileges for confidential communications known to the common law." *Upjohn Co. v. United States*, 449 U.S. 383, 389, 101 S. Ct. 677 (1981) (citing 8 J. Wigmore, Evidence § 2290 (McNaughton rev. 1961).

Its purpose is to "encourage full and frank communications between attorneys and their clients and thereby promote broader public interest in the observance of law and administration of justice." *Id*. The privilege is necessary because proper legal assistance can only be given when it is free from "consequences or the apprehension of disclosure." *Id.* (quoting *Hunt v. Blackburn*, 128 U.S. 464, 470 (1888)).

The privilege is not restricted to clients who are individuals. It applies to clients that are corporations and other entities. *Id*. at 389–90 (citing *United States v. Louisville & Nashville R. Co.*, 236 U.S. 318, 336 (1915)); *see also*, *Commodity Futures Trading Comm'n v. Weintraub*, 471 U.S. 343, 348 (1985) (inanimate entities can assert the attorney client privilege just as an individual can). Government entities are no different. Under Arizona law, communications between a lawyer for a governmental entity and that entity's employees or agents are privileged when the communications are for obtaining or providing legal advice. A.R.S. § 12-2234(B). Allowing the government to engage in privileged communications with legal counsel is important. As the Second Circuit explained,

> In the context of legal advice to government officials, the privilege furthers a culture in which consultation with government lawyers is accepted as a normal, desirable, and even indispensable part of conducting public business. Abrogating the privilege undermines that culture and thereby impairs the public interest.

Am. C.L. Union v. Nat'l Sec. Agency, 925 F.3d 576, 589 (2d Cir. 2019) (internal quotations omitted). The privilege applies with "special force" in the government context because the privilege encourages government officials formulating policies in the public interest to consult with counsel. *Modesto Irrigation Dist. v. Gutierrez*, 1:06-CV00453 OWWDLB, 2007 WL 763370 (E. D. Cal. Mar. 9, 2007).

The privilege is not absolute. There are conditions where the privilege can be overcome including when advice of counsel is used as an affirmative defense, or when the privileged is waived through disclosure. Neither of those has happened in this case.

B. State Defendants Have Not Asserted An Advice of Counsel Defense.

Plaintiff argues that the attorney-client privilege is overcome because the State Defendants have asserted the "advice of counsel defense." This is not accurate. The State Defendants have not asserted advice of counsel as an affirmative defense in its Answer to the Amended Complaint. (Doc. 89 at 27:9–29:9.) The advice of counsel defense need not be asserted in a pleading, but it must be done through some affirmative act by a party to the case. *U.S. v. Amlani*, 169 F.3d 1189, 1195 (9th Cir. 1999). A court must examine whether the party, "through this affirmative act," puts the privileged information at issue. *Id*.

1. Interrogatory Responses Did Not Waive the Privilege.

Plaintiff claims the State Defendants affirmatively asserted an advice of counsel defense in responses to Interrogatory Nos. 1, 4, and 7. (Doc. 195 at 4:2-7.) As discussed below, the State Defendants did not affirmatively assert an advice of counsel defense nor did they imply one in any of those responses.

"In general, disclosing that legal counsel was consulted, the subject about which advice [was] received, or that action was taken based on that advice, does not necessarily waive the privilege protection." *Melendres v. Arpaio*, No. CV-07-2513-PHX-GMS, 2015 WL 12911719, at *3 (D. Ariz. May 14, 2015). In their interrogatory responses, the State Defendants disclosed that legal counsel was consulted and the subject for which advice it received. (Doc. 195-3, Ex. 3 at 3, 5, 7-8.) That is insufficient to waive the privilege. The State Defendants did not state: (i) what the legal advice was; (ii) whether there was any recommendation from legal counsel; (iii) whether they relied upon legal counsel's advice; (iv) whether actions were based on or justified by legal advice; or (v) what attorneys gave legal advice—whether outside legal counsel, in-house counsel at ADOA or the Governor's Office, or the Attorney General's Office. *Id.*

In some cases, when the subjective intent of the of a party is at issue, a party may waive the privilege by stating that its decision or actions were justified by the legal advice

it received. *Melendres*, 2015 WL 12911719, at *3. Nothing in the interrogatory responses indicate that legal advice justified any decision by the State Defendants. (Doc. 195-3, Ex. 3 at 3, 5, 7-8.) An analysis of the State Defendants' responses cited by Plaintiff demonstrates there was no advice of counsel defense asserted.

a. Response to Interrogatory No. 1.

Plaintiff incorrectly suggests the State Defendants asserted advice of counsel defense and waived the privilege when explaining why the State Health Plan does not cover gender reassignment surgery. (Doc. 195-3, Ex. 3. at 4:4-14.) The State Defendants did not put the legal advice they received at issue, but only stated what the law was at the time of the decision to expand transgender benefits while continuing to exclude surgeries. The State Defendants did not state what the legal advice was and did not even state that they relied on advice from legal counsel. The State Defendants further stated that the legal advice received is privileged. (*Id.* at 3:17-18.) This was an *assertion* of the privilege, not a *waiver*.

Plaintiff wants the privileged communication in hopes of showing discriminatory intent. Plaintiff's desire does not make the privileged communications discoverable. Plaintiff and the Court need only consider the facts stated in the response to the Interrogatory regarding the status of the law that provided a backdrop to the State Defendants' consideration of changes to the Health Plan. At that time (in 2016), health plans were not required under Title VII of the Civil Rights Act or the Equal Protection Clause to cover transgender benefits. Discrimination on the basis of sex under Title VII or Equal Protection did not include transgender status. State Defendants' 2016 decision to expand coverage but keep the exclusion for "gender reassignment surgery" came four years prior to the Supreme Court's decision in *Bostock v. Clayton County, Georgia*, 140 S. Ct. 1731 (2020). Even *Bostock* was not dispositive on the issue of transgender benefit coverage.[2]

[2] *Id.* at 1741 (Alito, J., dissenting) ("Healthcare benefits may emerge as an intense battleground under the Court's holding.").

ADOA reviewed and *expanded* coverage for transgender services shortly after new rules had been issued by the Office of Civil Rights ("OCR") of the United States Department of Health and Human Services ("HHS"). HHS issued a final rule implementing non-discrimination provisions under § 1557 on May 18, 2016 (the "2016 Rules").[3] Notably, the 2016 Rules prohibited entities subject to the rules from including categorical exclusions or limitations for health services related to "gender transition." 45 CFR § 92.207(b)(4) (2016). However, the 2016 Rules did not affirmatively require coverage of any particular procedure or treatment for gender transition-related care. *Id*. at § 92.207(d) ("Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case"). Further, even if the 2016 Rules required that all transition-related surgeries be covered, they were then being challenged in court to determine if they were valid or whether they exceeded what is meant by "on the basis of sex" under the law.

The language of § 1557 is concise. Regarding discrimination on different bases, § 1557 incorporates different federal discrimination laws. *See* 42 U.S.C. § 18116 (A). For discrimination on the basis of sex, § 1557 incorporates Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.). *Id*.[4] Challenges to the validity of the 2016 Rules occurring when the State Defendants were considering changes to the State Health Plan focused on whether the 2016 Rules improperly exceeded the scope of what is meant by discrimination on the basis of sex in Title IX.[5]

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[3] *See*, Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 96, 31376 (May 18, 2016) (codified at 45 C.F.R. pt. 92).

[4] Section 1557 does not incorporate Title VII of the Civil Rights Act to define discrimination "on the basis of sex."

[5] The purpose of Title IX, when passed into law in 1972, was to establish equal educational opportunities for women and men. *Lothes v. Butler Cnty. Juvenile Rehab. Ct.*, 243 Fed. App'x. 950, 955 (6th Cir. 2007). Discrimination on the basis of sex under Title IX originally

On December 31, 2016, the United States District Court for the Northern District of Texas granted a motion for preliminary injunction enjoining HHS from enforcing § 1557 prohibitions against discrimination on the basis of gender identity because the definition of sex under the 2016 Rules exceeded the scope of Title IX. *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 696 (N.D. Tex. 2016). This case and related motions were pending when the ADOA was evaluating how it would address § 1557. In fact, the day after Texas District Court's ruling, the State Health Plan *expanded* transgender benefits to include hormone and counseling treatment, effective January 1, 2017.[6]

There has continued to be uncertainty regarding the validity and enforcement of § 1557. HHS issued new rules under § 1557 on June 19, 2020. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020). A few months later, the Federal District Court for the Eastern District of New York issued a preliminary injunction against the enforcement of those new rules. *Walker v. Azar*, No. 20CV2834FBSMG, 2020 WL 4749859, at *10 (E.D.N.Y. Aug. 17, 2020). Only recently (May 10, 2021), HHS announced that OCR would begin enforcing § 1557 and Title IX's prohibition on discrimination based on sex including discrimination

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meant male and female under traditional binary concepts of sex that is consistent with a person's birth or biological sex. *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215, 1222 (10th Cir. 2007). For many years, including shortly prior to the ADOA's decision to modify the Exclusion, courts held that discrimination on the basis of gender identity was not covered by Title IX. *See e.g.*, *Johnston v. Univ. Pittsburgh*, 97 F.Supp. 3d 657 (W.D. Penn 2015).

[6] Other cases challenging the meaning of "on the basis of sex" under Title IX were also occurring in 2016 when the State Defendants were considering changes to the Exclusion. On August 21, 2016, the Federal District Court for the District of Northern Texas issued a preliminary injunction enjoining the Department of Education from enforcing guidance it had issued regarding transgender student access to school facilities including restrooms. *Texas v. United States*, 201 F. Supp. 3d 810, 836 (N.D. Tex. 2016). The guidance, which included gender identity under Title IX protections against discrimination on the basis of sex, exceeded the scope and plain meaning of Title IX. *Id*. at 832-33. ("It cannot be disputed that the plain meaning of the term sex as used in § 106.33 when it was enacted . . . following passage of Title IX meant the biological and anatomical differences between male and female students as determined at their birth.").

on the basis of gender identity.[7]

In summary, regarding the State Defendants' response to Interrogatory No. 1, it only explained the context behind the State Defendants' 2016 decision as to the scope of their obligations. The State Defendants did not assert an advice of counsel defense, did not state what the legal advice was, did not indicate from whom any advice was received, and did not even state that they relied on advice from legal counsel. There was no waiver. Plaintiff's unexplained skepticism of the "State Defendants' actual understanding of the legality of the Exclusion" is no basis to force a governmental entity to divulge privileged communications. (Doc. 195 at 4, n. 2.) Plaintiff's logic would leave the attorney-client privilege susceptible to the unchecked skepticism of litigants or their counsel.

b. Response to Interrogatory No. 4.

Plaintiff next asserts that when the State Defendants identified persons who participated in "formulating, adopting, maintaining, reviewing, approving or deciding to continue" the Exclusion, the State Defendants somehow waived the privilege because three of the six people identified were lawyers. The notion is baseless. Plaintiff would have the Court hold that a waiver of privileged communications occurs whenever a party acknowledges that a lawyer was present at a meeting. This simply undercuts the privilege entirely since privileged communications can only occur when the conversation at issue involved the lawyer and his or her client. Indeed, if there were no lawyers listed as being present at the meeting, Plaintiff would have undoubtedly argued that the State Defendants were negligent in making a decision about the 2016 Rules without the assistance of lawyers and would have accused the State Defendants of discriminatory intent for *not* consulting with lawyers about the scope of their obligations. There was no statement in the

[7] *See* https://www.hhs.gov/about/news/2021/05/10/hhs-announces-prohibition-sex-discrimination-includes-discrimination-basis-sexual-orientation-gender-identity.html (last visited June 1, 2021).

interrogatory response about any legal advice.

Interrogatory No. 4 was also a compound question. A person listed could have been involved in reviewing the Exclusion, but might not have been involved in any other way such as formulating, adopting, maintaining, approving, or deciding anything about the Exclusion. Plaintiff's clearly overreaching argument is no basis for the Court to determine the State Defendants waived the privilege.

c. Response to Interrogatory No. 7.

Plaintiff argues that the State Defendants asserted an advice of counsel defense and thereby waived the attorney-client privilege by noting that the State Defendants "considered" two memos regarding § 1557. One memo was from outside legal counsel and the other was a memo to legal counsel at the Governor's Office about the memo from outside legal counsel. (Doc. 195-3, Ex. 3 at 7:17–8:1.) The State Defendants did not disclose any legal advice contained therein, did not indicate there was a recommendation from legal counsel, and did not state that the State Defendants relied on any advice of legal counsel. (*Id.*) The input of outside legal counsel was only described as a summary concerning implications of § 1557 and transgender coverage requirements. (*Id.*) The response only said the State Defendants "considered" counsel's summary among various other information ADOA gathered, including information from insurers and other entities regarding their experience providing transgender benefits. (*Id.*) The only other reference to the identified communications was that they are covered by the attorney-client privilege. (*Id.* at 7:22-23.) This was an assertion of the privilege—not a waiver. State Defendant's response to Interrogatory No. 7 is no basis for the Court to determine that the State Defendants have asserted an advice of counsel defense and no reason to conclude the State Defendants waived the privilege.

C. Deponent Testimony Did Not Waive The Privilege.

Plaintiff next argues that deposition testimony of two deponents were affirmative

acts by a party resulting in the assertion of the advice of counsel defense and the waiver of the privilege. This is wrong for two reasons.

1. Deponents Had No Authority To Waive Attorney-Client Privilege.

When the client at issue is a corporation or other entity, only those in authority to speak for the entity can assert or waive the privilege. *Commodity Futures Trading Com'n v. Weintraub*, 471 U.S. 343, 348 (1985). Inanimate entities do not speak directly to lawyers, but act through their agents. *Id*. Likewise, entities cannot directly assert or waive a privilege, but may do so through individuals "empowered to act on behalf of" the entity. *Id*.[8] Those without authority to speak on behalf of an entity cannot waive the privilege. *Id.* As the United States Supreme Court explained,

> [W]hen control of a corporation passes to new management, the authority to assert and waive the corporation's attorney-client privilege passes as well. New managers installed as a result of a takeover, merger, loss of confidence by shareholders, or simply normal succession, may waive the attorney-client privilege with respect to communications made by former officers and directors. Displaced managers may not assert the privilege over the wishes of current managers, even as to statements that the former might have made to counsel concerning matters within the scope of their corporate duties.

Id. at 349.

No statement by Scott Bender or former ADOA employee Marie Isaacson can waive the privilege because neither of them have authority to speak on behalf of Defendants Andy Tobin or Paul Shannon in their official capacities or on behalf of Defendant State of Arizona. Director Tobin and Mr. Shannon can speak for themselves in their official capacities, and neither Ms. Isaacson as a former ADOA employee (Declaration of Ryan Curtis ("Curtis Decl."), Ex. 14 at 87:19–88:9, filed concurrently, incorporated by reference), nor Mr. Bender as a benefits manager (Curtis Decl., Ex. 15 at 16:20–17:12) has authority

[8] As discussed above, governmental entities are not different than corporations or other entities when it comes to the attorney-client privilege.

to speak on behalf of the State of Arizona.

Plaintiff relies almost exclusively on testimony given by former ADOA employee Marie Isaacson. Ms. Isaacson retired from State employment in 2018. (Curtis Decl., Ex. 14 at 87:19–88:9.) When she testified at her deposition on March 26, 2021, she was a former employee and had no authority to speak on behalf of the State Defendants. She could not waive the privilege any more than she could assert the privilege. *Smith v. Ergo Sols., LLC*, No. CV 14-382 (JDB), 2017 WL 2656096, at *4 (D.D.C. June 20, 2017). "[A]ny privilege that exists as to a corporate officer's role and functions within a corporation belongs to the corporation and not the officer." *U.S. v. Graf*, 610 F.3d 1148, 1159 (9th Cir. 2010) (quoting *Matter of Bevill, Bresler & Schulman Asset Mgmt. Corp.*, 805 F.2d 120, 124 (3d Cir. 1986)). This all means that after Ms. Isaacson left ADOA, she had no authority to speak on behalf of ADOA. Any authority she had to waive the privilege ended when she left ADOA.

2. No Statements By Deponents Asserted An Advice of Counsel Defense.

Even if Ms. Isaacson or Mr. Bender had authority to waive the attorney-client privilege, nothing they said during their depositions asserted an advice of counsel defense or waived the privilege. The Motion mischaracterizes deposition testimony, describing Ms. Isaacson's and Mr. Bender's testimony as stating that "legal advice" and "advice about what ADOA was required or not required to cover was the primary basis of ADOA's decision." (Doc. 195 at n.4.) The referenced deposition testimony, however, does not contain any reference to "legal advice" or even "advice." (Doc. 195-3, Ex. 6 at 31:8-13); (Doc. 195-3, Ex. 7 at 167:12–168:3.)

Moreover, despite Mr. Bender sitting through a full day of deposition questions, Plaintiff only referred to a few lines of Mr. Bender's deposition transcript to suggest he asserted an advice of counsel defense on behalf of the State Defendants. (Doc. 195-3, Ex. 7 at 167:12–168:3.) Mr. Bender testified, regarding the reasons for maintaining the Exclusion,

that "I *believe* there are several reasons, one being cost and the other being we didn't *feel* it was required for us to include -- or to eliminate the exclusion . . . ." (*Id*. (emphasis added).) Mr. Bender made no reference to legal advice or anything definitive about the laws at issue. He only said ADOA *felt* it was not required to cover reassignment surgery. Mr. Bender, recalling in 2021, *beliefs* and *feelings* he may have had five years prior in 2016 about what level of transgender benefits had to be covered is no basis to find that the privilege is waived.

D. <u>The Privilege Was Not Waived Based On Any Voluntary Disclosure.</u>

Plaintiff's final alternate argument is that the privilege was waived based on voluntary disclosures. First, Plaintiff again asserts that Ms. Isaacson volunteered the content of legal advice during her deposition and thereby waived the privilege for all communications under that subject matter. Second, Plaintiff argues that the privilege was waived by Ms. Isaacson providing a copy of a legal memo the ADOA had received from outside legal counsel to the Governor's Office. Both of these arguments are flawed.

1. Only Parties Can Waive The Privilege.

Plaintiff once again turns to deposition testimony by Ms. Isaacson to argue that she waived the privilege by divulging the content of the advice of legal counsel.[9] Plaintiff's argument is again flawed because Ms. Isaacson is not a party.

First, Plaintiff repeatedly mischaracterizes Ms. Isaacson's deposition testimony to argue that she disclosed "the content" and "the substance of the legal advice provided to State Defendants regarding the Exclusion." The deposition testimony attached to Plaintiff's Motion does not support these assertions. Plaintiff states, for example, "Ms. Isaacson disclosed the content of this legal advice to Ms. Christina Corieri, a representative of the Governor's Office, in telephone calls." (Doc. 195 at 6:11-13.) Ms. Isaacson actually testified, however, not that she disclosed the content of the legal advice to Ms. Corieri, but

[9] Plaintiff makes no reference to any deposition testimony Mr. Bender gave that divulged the content of legal advice ADOA received regarding the Exclusion.

that she simply shared the fact that ADOA engaged legal counsel to research the legal requirements. (Curtis Decl., Ex. 14 at 42:6-18.) Plaintiff later characterizes Ms. Isaacson as "forthrightly disclos[ing] some of the content of legal advice received by State Defendants regarding the legality of the Exclusion . . . without prompting from the examining counsel." (Doc. 195 at 13:11–15.) Yet the cited portion of Ms. Isaacson's testimony, which was made in response to questions from examining counsel, does not reference legal advice. (Doc. 195-3, Ex. 6 at 19:6–24.)

Second, as Plaintiff noted, "[t]he Ninth Circuit has adopted a three-prong test to evaluate whether a *party* has waived the attorney-client privilege." (Doc. 195 at 8:10-13 (emphasis added).) The first prong is that "the court considers whether the *party* is asserting the privilege as the result of some affirmative act." *Amlani*, 169 F.3d at 1195 (emphasis added). Ms. Isaacson is not a party and was not affiliated with any party once she retired in 2018. She cannot waive the privilege on behalf of a party.

Plaintiff cites to numerous cases as examples of waiver of the privilege. In each of those cases, parties, who held the privilege, took some action to waive the privilege. *Amlani*, 169 F.3d at 1191 (criminal defendant and party to the case, Altaf Amlani, waived the privilege); *Chevron Corp. v. Pennzoil Co.*, 974 F.2d 1156, 1163 (9th Cir. 1992) (defendant and party Pennzoil waived the privilege); *Weil v. Investment/Indicators, Research and Management, Inc.,* 647 F.2d 18, 7 (9th Cir. 1981) ("We conclude, therefore, that the Fund [Investment/Indicators] has waived its attorney-client privilege"); *Melendres v. Arpaio*, No. CV-07-2513-PHX-GMS, 2015 WL 12911719, at *2 (D. Ariz. May 14, 2015) ("Defendant Sheriff Arpaio implicitly invoked the defense of advice of counsel by testifying that he had delegated MCSO's compliance with Preliminary Injunction to "counsel and relied on them to abide by this order"); *State Farm Mut. Auto. Ins. Co., v. Lee*, 13 P.3d 1169 (Ariz. 2011) ("State Farm implicitly asserted the advice of counsel as a defense when it made its claim of good-faith conduct turn on its legal research."); *U.S. v. Sanmina Corporation*, 958 F.3d

1107, 1125 (9th Cir. 2020) ("Sanmina waived the attorney-client privilege when it disclosed the Attorney Memos to DLA Piper"); *Hernandez v. Tanninen*, 604 F.3d 1095, 1100 (9th Cir. 2010) ("the district did not clearly err by concluding that Hernandez waived both privileges as they pertained to the conspiracy claim").

Plaintiff has cited to no authority in which a non-party witness, including a witness who is a former employee, could waive the attorney-client privilege for her former employer. Plaintiff never addresses the fact Ms. Isaacson is a non-party former employee who cannot waive the privilege even though the State Defendants provided contrary authorities to Plaintiff by email on May 10, 2021. (Doc. 195-3, Ex. 12 at p. 2.)

2. Communications With the Governor's Office Are Attorney-Client Privileged Under the Common Interest Doctrine.

Plaintiff next argues that the State Defendants waived the attorney-client privilege by disclosing legal research they received from their counsel to the Governor's Office. Voluntary disclosure to a third party will generally defeat privilege claims. *Sanmina Corp.*, 968 F.3d at 1116. However, Plaintiff's arguments fail to consider the relationship between ADOA and the Governor's Office.

The Governor has the power and duty under the Arizona Constitution and State law to transact *all* executive business with the officers of Arizona's government and to supervise the official conduct of *all* executive officers. *See* A.R.S. Const. Art. 5 § 4; A.R.S. § 41-101(A)(1). The Governor appoints the director of ADOA. A.R.S. § 41-701. Suggesting that sharing legal advice ADOA receives about the State Health Plan with the Governor's Office waives the attorney-client privilege is comparable to suggesting that the United States Secretary of State waives any privilege by sharing information with the White House. While ADOA and the Governor's Office are separate entities and have their own legal counsel for different matters, that does not mean (as Plaintiff suggests) they are unrelated parties with incongruent interests that defeat the common interest doctrine.

The common interest doctrine allows ADOA to share legal advice it receives related to the State Health Plan with the Governor's Office. The attorney-client privilege covers "common interest" situations and provides "an exception to ordinary waiver rules designed to allow attorneys for different clients pursuing a common legal strategy to communicate with each other." *In re Pac. Pictures Corp.*, 679 F.3d 1121, 1129 (9th Cir. 2012). The common interest privilege is not limited to "joint defense" situations "or even situations in which litigation has commenced." *See, e.g., U.S. v. Gonzalez*, 669 F.3d 974, 978 (9th Cir. 2012) (holding that common interest agreement "may be implied from conduct and situation, such as attorneys exchanging confidential communications from clients who are *or potentially may be codefendants* or have common interests in litigation") (emphasis added); *see also, e.g., id.* at 980 (noting that there is no requirement that parties asserting a common interest privilege be defendants in the same action, explaining that "parties in separate actions might nonetheless have reasons to work together toward a common objective, and there is no requirement that actual litigation even be in progress").

Moreover, the "common interests" to which the privilege extends are not limited to "legal" interests, but may also be "factual or strategic in character." *See* RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 76, cmt. e; *see also, e.g., Hunydee v. U.S.*, 355 F.2d 183, 185 (9th Cir. 1965) (affirming that communications may be protected by the common interest privilege, "even though exchanged between attorneys . . . to the extent they concern common issues and are intended to facilitate representation in *possible* subsequent proceedings") (emphasis added). Because the need to protect the free flow of information from client to attorney logically exists whenever multiple parties share a common interest about a legal matter, courts have extended the joint defense or common interest doctrine to numerous relationships among different parties. *In re Grand Jury Subpoenas, 89-3 & 89-4, John Doe 89-129*, 902 F.2d 244, 249 (4th Cir. 1990). This includes parties to *potential* litigation. *Gonzales*, 669 F.3d at 980 ("there is no requirement that actual

litigation even be in progress"); *see also United States v. Schwimmer*, 892 F.2d 237, 243–44 (2d Cir. 1989) ("it is therefore unnecessary that there be actual litigation in progress for the common interest rule of the attorney-client privilege to apply"). It also includes related governmental agencies "engaged in a common effort" to fulfill their legal obligations. *See Modesto Irrigation Dist.*, 2007 WL 763370 at *16.

Plaintiff argues that there is no evidence of any potential litigation surrounding communications between ADOA and the Governor's Office at the time of the disclosure. This is incorrect.

First, as noted above, there were numerous legal challenges to the 2016 Rules occurring when the State Defendants were considering changes to the State Health Plan.

Second, litigation against health plans seeking coverage for transgender benefits under § 1557 was not some remote possibility, but was a likelihood the State Defendants had to consider. On June 6, 2016, a transgender man and employee of Dignity Health's Chandler Regional Medical Center in Arizona filed suit against his employer under Title VII and § 1557 seeking coverage to treat his gender dysphoria.[10]

Third, and perhaps most importantly, the Court only needs to consider that litigation did in fact occur—this very case. ADOA and the Governor's Office are right now involved in the litigation brought by Plaintiff with respect to the Exclusion. ADOA's Director and its Acting Assistant Director of the Benefits Services Division are Defendants in this case and Plaintiff has subpoenaed the Governor's Office seeking evidence to use in this case. (Doc. 161 (Plaintiff's Notice of Subpoena to the Governor's Office)). The State Defendants also understand Plaintiff may be filing a third Motion to Compel, this time against the Governor's Office. It is certainly understandable that ADOA and the Governor's Office had a common interest, that would have involved considerations about possible litigation, when

[10] *Robinson v. Dignity Health d/b/a Chandler Regional Medical Center*, Case No. 4:16-cv-03035 (N.D. Calif. Filed June 6, 2016)

exchanging information in 2016 about transgender benefits.

Plaintiff seems to be suggesting ADOA and the Governor's Office should have to demonstrate they had a common interest in this very suit (filed on January 23, 2019 (Doc. 1)) when exchanging information in 2016. (Doc. 195 at 12:16-19.) Plaintiff's argument makes no sense. Plaintiff also makes misleading references to testimony by Ms. Isaacson who confirmed she had prior discussions with the Governor's Office that were not about this lawsuit and that she did not specifically discuss costs of litigation. (Doc. 195-3, Ex. 6 at 72:16–25; 179:24–180:1.) Neither of those statements indicates there was no consideration about potential litigation.

There was no disclosure through deposition testimony by Ms. Isaacson or to the Governor's Office that waived the important privilege.

E. Plaintiff's Motion Fails To State What Documents Plaintiff Demands.

Plaintiff's Motion is further flawed because it does not identify which documents Plaintiff seeks to compel. Plaintiff makes reference to 85 documents on the State Defendants' privilege log dated May 10, 2021, but Plaintiff never identifies which of those documents he purports was improperly withheld. Even if there was a waiver of the attorney-client privilege (there was not), Plaintiff has not explained to which documents such a waiver would apply. Plaintiff's failure makes it impossible for the State Defendants to properly oppose the Motion or for the Court to grant it.

II. CONCLUSION.

For the foregoing reasons, the attorney-client privilege and the common interest doctrine apply to the withheld documents. The Court should deny Plaintiff's Motion to Compel. Alternatively, the Court should review the individual documents that are the subject of the Motion to determine which are still privileged and only order disclosure of those that are not.

DATED this 3rd day of June, 2021.

FENNEMORE CRAIG, P.C.

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Amy Abdo
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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. State of Arizona, *et al.* Defendants.	No. 4:19-cv-00035 **DECLARATION OF RYAN CURTIS IN SUPPORT OF DEFENDANTS STATE OF ARIZONA'S, ANDY TOBIN'S, AND PAUL SHANNON'S OPPOSITION TO PLAINTIFF'S (SECOND) MOTION TO COMPEL**

I, Ryan Curtis, submit this declaration under penalty of perjury pursuant to 28 U.S.C. § 1746 and declare as follows:

1. I am a Director at Fennemore Craig, P.C., am licensed to practice law in the State of Arizona, and am lead counsel for Defendants State of Arizona, Andy Tobin, and Paul Shannon (collectively, the "State Defendants").

2. I submit this declaration in support of the State Defendants' Opposition to Plaintiff's (Second) Motion to Compel, filed concurrently.

3. I base this declaration on my personal knowledge and on information obtained in the course of the above-captioned matter.

4. Attached as **Exhibit 14** is a true and correct copy of excerpts of the Marie Isaacson Deposition Transcript, dated March 26, 2021.

5. Attached as **Exhibit 15** is a true and correct copy of excerpts of the Scott Bender Deposition Transcript, dated March 31, 2021.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED this 3rd day of June, 2021.

By: _____
Ryan Curtis

18477224

EXHIBIT 14

In The Matter Of:

Toomey vs.

State of AZ

Marie Frances Isaacson

March 26, 2021

Glennie Reporting Services, LLC

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IN THE UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,

Plaintiff,

vs. 4:19-cv-00035

STATE OF ARIZONA; ARIZONA BOARD OF REGENTS, D/B/A UNIVERSITY OF ARIZONA, a governmental body of the State of Arizona; et al.,

Defendants.

VIDEOTAPED DEPOSITION OF MARIE FRANCES ISAACSON

Via Zoom videoconference
March 26, 2021
8:21 a.m.

Glennie Reporting Services, LLC
1555 East Orangewood Avenue
Phoenix, Arizona 85020

602.266.6535
www.glennie-reporting.com

Prepared by:

Jill Marnell, RPR
Arizona Certified
Reporter No. 50021

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INSTRUCTIONS TO THE WITNESS NOT TO ANSWER

VIDEOTAPED DEPOSITION OF MARIE FRANCES ISAACSON

The deposition of MARIE FRANCES ISAACSON was taken on March 26, 2021, commencing at 8:21 a.m., via Zoom videoconference, before JILL MARNELL, a Certified Reporter, Certificate No. 50021, for the State of Arizona.

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Also present were:

Michael Noonan, videographer

Kim Suciu

Stephanie Rosenberg, via videoconference

THE VIDEOGRAPHER: We are on the record. Today's date is March 26, 2021. The time on the video monitor is 8:21 a.m. Here begins Video Number 1 in the deposition of Marie Isaacson in the matter of Russell B. Toomey versus State of Arizona, et al., in the United States District Court District of Arizona, Case Number 4:19-CV-00035.

The court reporter is Jill Marnell, representing Glennie Reporting Services, 1555 East Orangewood Avenue, Phoenix, Arizona 85020. My name is Michael Noonan. I'm the certified legal video specialist in association with Forensic Video Deposition Services, 11111 North Scottsdale Road, Suite 205, Scottsdale, Arizona 85254.

This deposition is taking place at the law offices of Fennemore Craig, PC, 2394 East Camelback Road, Suite 600, Phoenix, Arizona, 85016.

Counsel will now state their appearance and everyone else appearing remotely for their appearance and affiliations and anyone else attending remotely, beginning with the plaintiff, please.

MR. WALL: Good morning. This is Jordan Wall of Willkie Farr & Gallagher. I am joined in the room by my colleagues Victoria Sheets and Justin Garbacz. I'm also joined by my colleague telephonically Brandon Villa.

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Q. Could you tell us what they are?
A. Aetna, Cigna, Blue Cross Blue Shield of Arizona, and UnitedHealthcare.
Q. Did any of those companies offer surgery -- surgery for gender dysphoria, on any of their commercial plans or any plans at all?
A. You know, I know we received the emails, but I don't remember what the response was.
Q. You don't remember whether you could have asked Aetna, for example, whether they covered gender dysphoria surgery and what answer they gave you?
A. I remember asking the question of all four plans. I don't remember which -- what plan responded with what answer.
Q. Okay. But you do remember that some of the plans told you, yes, and we do cover gender dysphoria surgery?
A. My biggest recollection is that it was not covered, the majority of the response was it was not covered.
Q. Majority. So that -- Was there a minority that did cover it?
A. I think so. I --
Q. Okay. Well, we can -- we can look at exhibits to ferret that out.
Do you recall any states offering surgery

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for gender -- gender dysphoria under their State plans?
A. Well, just based on the email from Chanelle that we just looked at, those states do offer transgender benefits. But I guess based on this I don't know whether it's surgery or what the benefits are.
Q. Okay. Was one of the issues in determining whether the plan offered by the Arizona Department of Administration for employees of the State of Arizona, which included the faculty and staff at -- at the universities, based on the cost of that benefit?
A. I would say that in researching it that was one of the items that we did research, was the cost of the benefit.
Q. And you determined that the cost was de minimis, didn't you?
A. As I recall there was a range of costs.
Q. And based on additions to premiums for those who participated in the plan, what was the range? Cents per premium.
A. I -- I know we just reviewed that last Sunday, but I can't -- I don't remember what the range was.
Q. Well, it was as low as three cents. Do you recall that?
A. I don't recall.
Q. Okay. But you recall that all the additions were

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under a dollar per plan.
A. I --
MR. CURTIS: Objection.
MR. ECKSTEIN: Per employee. Per employee per plan.
THE WITNESS: I -- I -- I don't remember, Paul.
Q. BY MR. ECKSTEIN: Okay. Well, we'll -- we'll take a look.
Thinking back, did you believe that the -- the cost that was estimated was -- was too high to justify providing that benefit?
A. I don't remember that being -- We discussed cost, but I don't remember that being the driving factor in the discussion.
Q. What was the deciding factor?
A. What was required by law. What was required by law for us to cover.
Q. So as you recall it, if the -- Strike that.
As you recall it, the persons making the decisions were focused on what was legally required. And if it wasn't legally required, surgery for gender dysphoria was not going to be offered in the plan.
A. What I recall is that there was a decision that had to be made, and reaching out to the health plans,

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doing research ourselves to -- to gather as much information as possible to make a decision.
Q. Do you consider yourself part of the group that made that decision?
A. I would say no.
Q. Who was in the group that made the decision?
A. Legal counsel and the governor's office and the director's office.
Q. Did you consult with anyone in the legislature, particularly the Joint Legislative Budget Committee, JLBC, as to the wisdom of covering surgery for gender dysphoria?
A. No.
Q. Did anyone from the legislature weigh in and tell you their thoughts?
A. No.
Q. Did you ever hear that anyone from the legislature had weighed in and given thoughts on that?
A. No.
Q. Was this considered a political issue of any kind?
A. Not that anyone raised to me, no.
Q. Did you hear secondhand that there was concern about the politics of including surgery for gender dysphoria?
A. No.

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Q. Did the plan during the time you had involvement with it cover any services, health services, that were not required by law?
A. I don't know. I mean, I'm sure there are services that aren't required by law that were part of the plan description. The plan was adopted from when we were fully insured. So, you know, I'm assuming there are things that are covered that aren't required.
Q. Do you recall what they might be?
A. I think some plans offered healthy back. You know, that's the one that comes to my mind.
Q. But that was not required by law?
A. Not to my knowledge.
Q. So there was no general policy at ADOA to cover health benefits only if they were required by law; isn't that correct?
A. I would say that's correct.
Q. Other than coverage for healthy backs, can you recall any other services that were not required by law that were offered in the plan?
A. Not off the top of my head, no.
Q. You say that this one meeting took place and may or may not have been around this time in September. We'll look at other documents to see if we can pin it down. Do you recall how many times you did meet with the governor's

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office on this issue?
A. I recall one meeting in the governor's office -- specifically one meeting in the governor's office and at least a phone call with Christina Corieri. Those -- those are the two things that I remember.
Q. Okay. Do you recall whether the telephone call with Christina was before or after the meeting that we've been talking about?
A. I would say there was at least one phone call with her before the meeting.
Q. And what was the nature of that call?
A. I think we're sharing with her that we had engaged Fennemore Craig to do some research.
Q. On the legality, whether it was required by law?
A. Yes.
Q. Okay. And that was it? That was the conversation?
A. As much as I recall, yes.
Q. Did you ever meet with the governor on this issue of surgery for gender dysphoria?
A. No.
Q. Did anyone at ADOA meet with the governor on this issue?
A. I don't know.
Q. Did anyone at the meeting that you've referenced

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at which Mike Liburdi and you and others attended say that they had discussed this matter with the governor?
A. Not that I recall.
Q. Did anyone there say that the governor had a point of view on this issue?
A. Not that I recall.
Q. What position did Scott Bender have at the -- in September of '16 at or around the time this meeting took place?
A. Plan administration manager.
Q. And did he report to you?
A. Yes.
Q. Let's turn to Tab 26. We'll mark that, if it hasn't been marked, as ABOR Exhibit 102. And if you will go to Bates Page Number 119501 of that exhibit, which is the last -- or the first, the first email in this string. You'll see an email from Nicolette Schultz to Jill Metzinger, with a copy of Christina Corieri.
See that?
A. Yes.
Q. It doesn't appear that you got a copy of that email when it was sent in September of 2016. And I'm looking to see whether you were copied on any of the other emails, but I'm not sure that you were.
Do you recall seeing this string of emails

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when you were shown documents?
A. I do.
Q. You do. Okay.
Did you recall it before you saw it?
A. No.
Q. All right. Let's -- let's focus on that very first email which is dated September 1. And it says -- and I'm translating generously, or maybe not so generously -- that there was a discussion at the last meeting regarding transgender benefits that Christina Corieri would like to attend a meeting between the ADOA benefit services -- meaning and you and Nicole Ong -- and the Board of Regents.
Did such a meeting ever take place?
A. I -- I don't remember it.
Q. Do you recall meeting -- a meeting with anyone in the governor's office and you, a meeting with the Board of Regents or anyone in any of the universities?
A. I don't doubt that it could have taken place but I don't remember it.
Q. It's not one that sticks out in your mind?
A. No.
Q. Did they report one to you?
A. No.
Q. They, meaning Nicolette. What's her title? What

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office manager.
Q. And do you remember the name of that law firm?
A. Bosco & DiMatteo.
Q. Could you spell that first name. I think you said Bosco.
A. Yes, B-O-S-C-O.
Q. And how long did you work at the Bosco law firm? Bosco -- And I'm sorry, would you actually spell the last name as well, DiMatteo.
A. Capital D, I, capital M, A-T-T-E-O.
Q. And how long did you work at Bosco & DiMatteo?
A. I -- I don't know. Four years maybe. I worked there before I got my degree and after.
Q. And when you're referring to your degree do you mean your BS or MBA?
A. BS.
Q. And so you worked at Bosco & DiMatteo for about four years. So until about 1989 or so?
A. No, I started in '83, I think.
Q. Oh, I see. So the four years was inclusive of your time while you were at Arizona State University?
A. Right.
Q. So you worked at Bosco & DiMatteo till when exactly?
A. I think August -- August of 1987.

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Q. And what did you do after you left their employ?
A. I went to work at the Attorney General's Office.
Q. Was that the Attorney General of the State of Arizona?
A. Yes.
Q. And how long did you work at the Attorney General's Office?
A. I'll have to think about it for a minute. Two -- two or three years.
Q. And what did you do in that job?
A. I was the -- My title was administrative assistant. Basically an office manager for one of the divisions, the financial fraud division.
Q. And have you kept in touch with anyone you worked with at the Attorney General's Office?
A. Yes.
Q. Who?
A. Lisa Flores, Cynthia Wolfe. I think those are the only two.
Q. Have you ever worked with either Ms. Flores or Ms. Wolfe in a professional capacity since leaving the Attorney General's Office?
A. Lisa Flores worked for Governor Hull when I worked at the Department of Administration. And I had interaction with her in her professional capacity then.

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Q. And around what time was that?
A. Late nineties. Mid -- mid nineties.
Q. And did you ever work with Ms. Flores or Ms. Wolfe in connection with the ADOA's analysis of whether to cover transgender benefits?
A. No.
Q. And so after you left the Attorney General's Office -- Was that around 1990?
A. About that time, yes.
Q. Is that when you returned to ASU for your MBA?
A. No, I went to another -- I was working on my MBA as soon as I finished my bachelor's degree. And I -- when I left the Attorney General's Office I went to another position with the State of Arizona.
Q. And what was that position?
A. Personnel analyst.
THE COURT REPORTER: Personnel?
THE WITNESS: Yes.
Q. BY MR. WALL: And was that with a particular department?
A. I worked at the Arizona Department of Administration. It was paid for by the Arizona Department of Transportation. So I was an Arizona Department of Transportation employee assigned to Arizona Department of Administration.

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Q. And you began working there in around 1990?
A. Yes.
Q. Ms. Isaacson, I think you testified earlier that you worked at the ADOA for approximately 25 years. Is that right?
A. Yes.
Q. So you were working at the ADOA continuously from this job beginning in 1990, until around 2015?
A. 2018 is when I retired.
Q. So about 28 years, or so?
A. There were times where I was employed by AHCCCS and not the Department of Administration. I was employed by ADOT when I first started. So I was subtracting that time out of the time I worked for Arizona Department of Administration. I was continuously employed by the Arizona -- by the State of Arizona for almost 31 years.
Q. And what is AHCCCS?
A. The State's Medicaid plan.
Q. And could you tell me what that abbreviation stands for again?
A. Arizona Healthcare Cost Containment System.
Q. Would you describe yourself as intimately familiar with the workings of ADOA?
A. Currently?
Q. Let's clarify. Would you describe yourself as

EXHIBIT 15

In The Matter Of:

Toomey vs.

State of AZ

Scott Bender, Videotaped

March 31, 2021

Glennie Reporting Services, LLC

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

RUSSELL B. TOOMEY,

Plaintiff,

vs. 4:19-CV-00035

STATE OF ARIZONA; ARIZONA BOARD OF REGENTS, d/b/a UNIVERSITY OF ARIZONA, a governmental body of the State of Arizona; et al.,

Defendants.

VIDEOTAPED DEPOSITION OF SCOTT BENDER

Via Zoom Videoconference
March 31, 2021
8:00 a.m.
Phoenix, Arizona

Glennie Reporting Services, LLC
1555 East Orangewood Avenue
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602.266.6535
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Prepared by:
Robin L. B. Osterode
CSR, RPR
CA CSR No. 7750
AZ CR No. 50695

I N D E X

INDEX TO EXHIBITS

INDEX (Continued):

INDEX TO EXHIBITS

DEPOSITION OF SCOTT BENDER

The deposition of SCOTT BENDER, via Zoom Videoconference, was taken on March 31, 2021, commencing at 8:00 a.m., at Phoenix, Arizona, before ROBIN L. B. OSTERODE, RPR, CSR, California Shorthand Reporter No. 7750 and Arizona Certified Reporter No. 50695.

APPEARANCES:

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The Videographer:

Michael Noonan
(Videoconference appearance.)

Also Present:

Kimberly Suciu
(Videoconference appearance.)

THE VIDEOGRAPHER: We are on the record. Today's date is March 31st, 2021. The time on the video monitor is 8:05 a.m., standard time. Here begins video number one in the deposition of Scott Bender, in the matter of Russell B. Toomey versus State of Arizona, et al., in the United States District Court, District of Arizona, case number 4:19-CV-00035.

The court reporter is Robin Osterode representing Glennie Reporting Services, 1555 East Orangewood Avenue, Phoenix, Arizona 85020.

My name is Michael Noonan. I'm the certified legal video specialist, in association with Forensic Video Deposition Services, 11111 North Scottsdale Road, Suite 205, Scottsdale, Arizona 85254.

This deposition is taking place at the law offices of Fennemore Craig, 2394 East Camelback Road, Suite 600, Phoenix, Arizona 85016.

Counsel will now state their appearance and affiliations and everyone attending remotely and anyone else present in the room for the record, please, beginning with the plaintiffs.

MR. WALL: Good morning. This is Jordan Wall, from Willkie Farr & Gallagher, on behalf of the plaintiff Dr. Russell B. Toomey and certified classes. I'm joined by my colleagues, Victoria Sheets and Justin Garbacz in the room, and, on remotely, Brandon Villa.

MR. CURTIS: Good morning. This is Ryan Curtis with Fennemore Craig on behalf of the State defendants and Andy Tobin and Paul Shannon in their official capacity. Also in the room with me is Kim Suciu, associate general counsel for the Arizona Department of Administration.

MR. YOST: Good morning. This is Austin Yost on behalf of the Arizona Board of Regents. Also with me remotely is Paul Eckstein.

THE VIDEOGRAPHER: I apologize. Robin, did you get all that?

THE REPORTER: I did.

THE VIDEOGRAPHER: Would you please swear in the witness.

THE REPORTER: Before we proceed, I will ask counsel to agree on the record that there is no objection to this officer of the court administering a binding oath to a witness not appearing personally before me.

Please state your agreement on the record.

MR. CURTIS: State defendants have no objection.

MR. YOST: University defendants have no objection.

MR. WALL: Plaintiff has no objection.

SCOTT BENDER,
called as a witness herein, having been first duly sworn by the Certified Reporter to speak the whole truth and nothing but the truth, was examined and testified as follows:

THE VIDEOGRAPHER: Please begin when ready.

EXAMINATION

BY MR. WALL:

Q. Good morning, Mr. Bender. How are you?
A. I'm doing well, thanks. How are you?
Q. I'm doing all right.
Would you please state your full name and address for the record?
A. Yes. Scott Patrick Bender. My address is 893 South Gardner Drive, Chandler, Arizona 85224.
Q. And, Mr. Bender, are you being represented by Mr. Ryan Curtis today at this deposition?
A. Yes.
Q. And have you ever been deposed before?
A. No.
Q. Have you ever testified at trial?
A. No.
Q. Okay. So I'm going to go over some ground

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Q. And if you were shown those documents again today, would you recall them?
A. Very likely so.
Q. Did you bring anything to that preparation with Mr. Curtis and Ms. Suciu?
A. No.
Q. And have you discussed your deposition with anyone else, aside from Mr. Curtis and Ms. Suciu?
A. No.
Q. Mr. Bender, what is your understanding of this lawsuit?
A. My understanding is that Dr. Toomey is seeking to have his transgender surgery covered. The plan does not cover that. He believes that under Section 1557 or some other avenue that the plan should be covering that service, and the State feels otherwise.
Q. So, Mr. Bender, you're aware of Section 1557?
A. Yes.
Q. And what is -- what is Section 1557?
A. It's part of the Affordable Care Act, which addresses discrimination based on race, gender, et cetera, as it relates to employee benefit programs.
Q. And what is the relevance of Section 1557 to this lawsuit?
A. The relevance would be there is an argument

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that self-insured plans, like ours, should cover transgender surgery, and the State feels differently. Fully insured programs certainly do so.
Q. The State feels that its health plan should not cover transgender surgeries?
A. We have -- the State has the ability to opt in or opt out as a self-insured entity.
Q. But it does feel that its plan should not have to cover transgender surgery?
A. Correct.
Q. So before we go any further, Mr. Bender, I just want to clarify some terminology and language that we might be using today during the deposition. There's a lot of different conflicting terms or synonymous or related terms, so I think it will help us to understand -- to make sure we understand each other clearly.
A. Okay.
Q. First, I'd like to say that if I refer to the "ADOA," I'm referring to the Arizona Department of Administration; is that all right?
A. Yes.
Q. And by "State defendants," I'm referring to defendants in this lawsuit, the State of Arizona, Mr. Andy Tobin, who is the director of the ADOA, and

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Mr. Paul Shannon, who is the acting assistant director of the benefit services division of the ADOA.
Do you understand that?
A. Yes.
Q. By "ABOR," I'd be referring to the Arizona Board of Regents, the public universities of Arizona, including Arizona State University, the University of Arizona, and Northern Arizona University.
Do you understand that?
A. Yes.
Q. By "governor's office," I would be referring to the Arizona Governor's Office.
Do you understand that?
A. Yes.
Q. By "plan" I would be referring to the State of Arizona self-funded health plan controlled by the Arizona Department of Administration.
Do you understand that?
A. Yes.
Q. By "transgender benefits," I mean the range of healthcare services or treatments primarily related to the needs of individuals identifying either as transgender or experiencing symptoms of gender dysphoria.
Do you understand that?
A. Yes.

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Q. And by "transsexual surgery" or "gender reassignment surgery," I'm referring specifically to the healthcare services or treatments related to surgery in connection with the experience of gender dysphoria.
Do you understand that?
A. Yes.
Q. By the term "exclusion," I'm referring to the plan's exclusion of transsexual surgery, inclusive of medical and psychological counseling and hormone therapy in connection therewith, up until 2017, as well as the plan's exclusion of gender reassignment surgery following 2017.
Do you understand that?
A. Yes.
Q. And then, finally, by "Section 1557," I'm referring to the portion of the Affordable Care Act that we referenced earlier.
Do you understand that?
A. Yes.
Q. Mr. Bender, are you currently employed?
A. Yes, I am.
Q. By whom?
A. By the State of Arizona, Department of (inaudible) --
Q. I'm sorry, would you say that again?

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A. By the State of Arizona, Department of Administration.
Q. And what's your title in the Department of Administration?
A. I'm the plan administration manager.
Q. And how long have you held that title?
A. Since I was hired in December 2015.
Q. And so you've been the plan administration manager since you were hired in December of 2015?
A. Correct.
Q. And until present?
A. Yes.
Q. Have you ever held any other position with the Arizona Department of Administration?
A. No.
Q. Prior to the time -- prior to -- prior to your hiring by the Arizona Department of Administration, did you have any prior positions?
A. Yes.
Q. All right. Let's start, then -- actually, let's take -- let's start from the earliest and go and work forward, beginning with your education.
Mr. Bender, do you have a college degree?
A. I do.
Q. And from where?

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A. State University of New York at Oswego.
Q. And what degree did you receive from the State University of New York?
A. It was business administration. A bachelor's in business administration.
Q. Did you study any particular area of expertise with respect to business administration?
A. I studied a concentration in human resources.
Q. And what does a concentration in human resources entail?
A. It was -- it fell short of being a major at that time. It's basically focused on the various different disciplines within human resources.
Q. What are some of those disciplines?
A. Compensation, human resources law, some touching on benefits, a lot of compliance.
Q. When you say "touching on benefits," what does that entail?
A. This goes back to the mid-'90s, so forgive me if my memory is fuzzy, but just general what are pension plans and healthcare programs and the typical, you know, what are -- what are the various components of a health plan, things like that.
THE REPORTER: Mr. Bender -- Mr. Bender --
BY MR. WALL:

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Q. So when did you finish that degree at State University of New York?
A. 1995.
Q. So, to summarize, you received a bachelor of arts?
A. Yes.
Q. So you received a bachelor of arts from the State University of New York, where you studied business administration. Correct?
A. Correct.
Q. In that business administration degree, you had a human resources concentration?
A. Right.
Q. Which included the study of benefits, which included, as you said, things about pension plans and healthcare programs?
A. Yes.
Q. Do you have any other degrees?
A. No.
Q. Do you have a master's?
A. Actually, no, I have -- I had an associate's degree from a community college and then went to the four-year school.
Q. And where -- what community college was that from?

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A. Columbia Green Community College.
Q. And when did you receive it?
A. 1992.
Q. And what did you study?
A. Business administration.
Q. And were your studies similar to your studies at the State University of New York?
A. Very similar. It was more basics, accounting, things like that.
Q. When you say "accounting," what exactly did that entail?
A. It was basic accounting, accounting 1, accounting 2, corporate finance. Sort of your general business administration program.
Q. Did you do anything with respect to actuarial studies?
A. No.
Q. What about while you were studying at the State University of New York?
A. No.
Q. Do you understand what I mean when I say "actuarial studies"?
A. Yes.
Q. What does that entail?
A. Study of actuarial science, for --

EXHIBIT 6

WO

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. State of Arizona; Arizona Board of Regents, d/b/a University of Arizona, a governmental body of the State of Arizona; et al., Defendants.	CV 19-0035-TUC-RM (LAB) **ORDER**

Pending before the court is the plaintiff's motion, filed on May 20, 2021, to compel production of documents. (Doc. 195) The defendants State of Arizona, Andy Tobin, and Paul Shannon ("the State Defendants") filed a response on June 4, 2021. (Doc. 202) The plaintiff, Russell B. Toomey, filed a reply on June 10, 2021. (Doc. 205)

Toomey served on the State Defendants his First Request for Production on December 8, 2020. (Doc. 195) "Request Nos. 1, 3, and 9 specifically sought documents and information concerning the [State's health insurance plan] Exclusion [for gender reassignment surgery] and the decision-making behind it." (Doc. 195, p. 4) The State Defendants withheld 85 documents on the basis of attorney-client privilege. *Id.* In the pending motion, Toomey seeks an order from this court compelling production of those documents.

The motion will be granted. The State Defendants maintain that the Exclusion is not the product of intentional discrimination. It exists, they say, because they were advised by counsel that it is legal and nothing in the law requires the State's health insurance plan to cover gender reassignment surgery. By allegedly relying on this legal advice as evidence that they harbored

no discriminatory intent, the State Defendants have waived by implication the attorney-client privilege as to that advice. The court does not reach Toomey's alternate arguments.

Discussion

The plaintiff in this action, Russell B. Toomey, is an associate professor employed at the University of Arizona. (Doc. 86, p. 5) (Amended Complaint) He receives health insurance from a self-funded health plan ("the Plan") provided by the State of Arizona. (Doc. 86, pp. 3, 8) The Plan generally provides coverage for medically necessary care. (Doc. 86, p. 8) There are coverage exclusions, however, one of which is for "gender reassignment surgery" ("the Exclusion"). (Doc. 86, p. 9)

Toomey is a transgendered man. (Doc. 86, p. 9) "[H]e has a male gender identity, but the sex assigned to him at birth was female." (Doc. 86, p. 9) Toomey has been living as a male since 2003. (Doc. 86, p. 9) His treating physicians have recommended that he receive a hysterectomy as a medically necessary treatment for his gender dysphoria. (Doc. 86, p. 9) Toomey sought medical preauthorization for a total hysterectomy, but he was denied under the Plan's exclusion for gender reassignment surgery. (Doc. 86, p. 10)

On January 23, 2019, Toomey brought the pending class action in which he argues the Plan's Exclusion is sex discrimination under Title VII of the Civil Rights Act of 1964 and a violation of the Equal Protection Clause of the Fourteenth Amendment. (Doc. 1); (Doc. 86)

This action is currently in the discovery stage. On December 8, 2020, Toomey served his First Request for Production on the State Defendants seeking documents calculated to reveal the reason why the Plan contains an exclusion for gender reassignment surgery. (Doc. 195, p. 4) The State Defendants produced a privilege log identifying 85 documents withheld "on the basis of attorney-client privilege." (Doc. 195, p. 4)

In the pending motion, Toomey moves to compel the production of these documents pursuant to Fed.R.Civ.P.37(a)(3)(B). (Doc. 195, p. 2); *see also* LRCiv 37.1 He asserts that the State Defendants implicitly waived the attorney-client privilege "by asserting and relying on

legal advice as a defense to the charge that discriminatory intent . . . motivat[ed] their decision to maintain the Exclusion, effectively placing this legal advice at issue." (Doc. 195, p. 3) He further argues that the State Defendants waived the privilege by sharing that legal advice with the Governor's office and himself. (Doc. 195, pp. 3-4)

In general, "[p]arties may obtain discovery regarding any nonprivileged matter that is relevant to any party's claim or defense and proportional to the needs of the case, considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit." Fed. R. Civ. P. 26(b)(1).

Pursuant to Fed. R. Civ. P. 37(a)(3)(B)(iv), "A party seeking discovery may move for an order compelling . . . production . . . if . . . a party fails to produce documents." In this case, the State Defendants resist production of 85 documents based on the attorney-client privilege. "The party asserting an evidentiary privilege has the burden to demonstrate that the privilege applies to the information in question." *Tornay v. United States*, 840 F.2d 1424, 1426 (9th Cir.1988) (construing the attorney-client privilege). Where, as here, federal law provides the rule of decision, the contours of an evidentiary privilege are governed by federal common law. Fed. R. Evid. 501.

"The attorney-client privilege protects confidential communications between attorneys and clients, which are made for the purpose of giving legal advice." *United States v. Sanmina Corp.*, 968 F.3d 1107, 1116 (9th Cir. 2020). "Whether information is covered by the attorney-client privilege is determined by an eight-part test: (1) Where legal advice of any kind is sought (2) from a professional legal adviser in his capacity as such, (3) the communications relating to that purpose, (4) made in confidence (5) by the client, (6) are at his instance permanently protected (7) from disclosure by himself or by the legal adviser, (8) unless the protection be waived." *Id.* In this case, the parties dispute only element (8) – the issue of waiver.

Waiver may be express or implied. An express waiver "occurs when a party discloses privileged information to a third party who is not bound by the privilege, or otherwise shows disregard for the privilege by making the information public." *Id.* at 1117. "In contrast, waiver by implication, or implied waiver, is based on the rule that a litigant waives the attorney-client privilege by putting the lawyer's performance at issue during the course of litigation." *Id.* "Waivers by implication rest on the 'fairness principle,' which is often expressed in terms of preventing a party from using the privilege as both a shield and a sword." *Id.* "In practical terms, this means that parties in litigation may not abuse the privilege by asserting claims the opposing party cannot adequately dispute unless it has access to the privileged materials." *Id.*

In this case, the State Defendants maintain that the Exclusion is not the product of intentional discrimination. It exists in large part, they say, because the State Defendants were advised that it is legal and nothing in the law requires the Plan to cover gender reassignment surgery. By allegedly relying on this legal advice to explain their actions, the State Defendants have waived by implication their attorney-client privilege as to that advice. The State Defendants argue generally that they never raised an "advice of counsel defense." The record, however, indicates otherwise.

In their answer to Toomey's interrogatories, the State Defendants stated that that the Plan contains the Exclusion, in part, "because the State concluded, under the law, that it was not legally required to change its health plan to provide such coverage under either Title VII of the Civil Rights Act or under the Equal Protection clause of the Fourteenth Amendment to the United States Constitution." (Doc. 195, p. 5); (Doc. 195-3, p. 53) The State Defendants explicitly asserted that, "The legal advice that the State received regarding this issue is covered by the attorney-client privilege." (Doc. 195-3, p. 53) The State Defendants specifically identified two memoranda, one from Marie Isaacson, dated August 3, 2016, and one from outside legal counsel Fennimore Craig, P.C., dated July 20, 2016, as documents covered by attorney-client privilege that were "considered, reviewed, or relied on by Defendants relating

to the Exclusion." (Doc. 195, pp. 5-6) In their respective depositions[1], Marie Isaacson, Director of the Benefits Service Division of the Arizona Department of Administration (ADOA) from 2015-2018, and Scott Bender, Plan Administration Manager of the ADOA from 2015-present, testified that "the deciding factor" or the "primary reason" for the continuing existence of the Exclusion was that the law did not require gender reassignment surgery to be covered. (Doc. 195, p. 6) Isaacson stated that "We sought legal counsel and that – with the legal counsel's recommendation and meeting with the governor's office there was a decision made – a conclusion made to cover some services . . . . The counseling and hormone therapy were covered. And surgery was not covered." (Doc. 195-3, p. 65, depo. p. 19, lns.8-15)

Toomey cannot adequately dispute this proffered reason for the actions of the State Defendants, that it was legal, without access to the legal advice that the State Defendants received. "Fairness" dictates that they disclose that legal advice to him. *See, e.g, Chevron Corp. v. Pennzoil Co*., 974 F.2d 1156, 1162–63 (9th Cir. 1992) ("[T]o the extent that Pennzoil claims that its tax position is reasonable because it was based on advice of counsel, Pennzoil puts at issue the tax advice it received.").

In their response, the State Defendants argue that they never asserted an "advice of counsel defense." (Doc. 201, p. 5) They did say that the Plan contains the Exclusion "because the State concluded, under the law, that it was not legally required to change its health plan . . . ." But this was simply their understanding of "what the law was at the time of the decision to expand transgender benefits while continuing to exclude surgeries." (Doc 201, p. 6) Their understanding, they assert, was not necessarily based on the advice of counsel. The court is not convinced.

If the State Defendants' understanding of the law was based, say, on a newspaper article, then they would not have affirmatively stated that "[t]he legal advice that the State received

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[1] The State Defendants identified Isaacson and Bender as "persons with knowledge of the genesis, formulation, adoption, maintenance, or continuation of" the Exclusion. (Doc. 195-3, p. 32)

regarding this issue is covered by the attorney-client privilege." (Doc. 195-3, p. 53) The attorney-client privilege does not cover newspaper articles. Moreover, the State Defendants specifically identified two memoranda, one from Marie Isaacson, dated August 3, 2016, and one from outside legal counsel Fennimore Craig, P.C., dated July 20, 2016, as documents covered by attorney-client privilege that were "considered, reviewed, or relied on by Defendants relating to the Exclusion." (Doc. 195, pp. 5-6) The court concludes that the State Defendants' understanding of the law was based in large part on advice from counsel.

With regard to the memoranda, the State Defendants insist that they "did not disclose any legal advice contained therein, did not indicate there was a recommendation from legal counsel, and did not state that the State Defendants relied on any advice of legal counsel." (Doc. 201, p. 10) The court is not persuaded. The State Defendants implied that they received legal advice on the propriety of the Exclusion from counsel and relied on that legal advice when they decided to establish or maintain the Exclusion even if they did not say so explicitly. "Fairness" dictates that Toomey is entitled to discover what that advice was. That advice is not shielded from discovery by the attorney-client privilege.

IT IS ORDERED that the plaintiff's motion, filed on May 20, 2021, to compel production of documents is GRANTED. (Doc. 195) The State of Arizona, Andy Tobin, and Paul Shannon (The State Defendants) shall "produce all the documents currently withheld on the basis of attorney-client privilege they received on the legality of the Exclusion . . . ." The State Defendants shall comply with this order within 14 days of service.

DATED this 28th day of June, 2021.

Leslie A. Bowman

Leslie A. Bowman
United States Magistrate Judge

EXHIBIT 7

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State of Arizona, Andy Tobin, and Paul Shannon

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey, Plaintiff, v. State of Arizona, *et al.* Defendants.	No. 4:19-cv-00035 **DEFENDANTS STATE OF ARIZONA'S, ANDY TOBIN'S, AND PAUL SHANNON'S OBJECTIONS TO ORDER** **(Oral Argument Requested)**

Defendants State of Arizona (the "State"), Andy Tobin, and Paul Shannon (collectively, the "State Defendants") hereby submit their Objections to Magistrate Judge Bowman's Order (Doc. 213) (the "Order"), dated June 28, 2021, which granted Plaintiff's Motion to Compel Production of Documents (Doc. 195) (the "Motion").

I. THE STATE DEFENDANTS DID NOT ASSERT NOR IMPLY AN ADVICE OF COUNSEL DEFENSE.

"[D]isclosing that legal counsel was consulted, the subject about which advice [was] received, or that action was taken based on that advice, ***does not necessarily waive the privilege protection***." *Melendres v. Arpaio*, No. CV-07-2513-PHX-GMS, 2015 WL

12911719, at *3 (D. Ariz. May 14, 2015) (emphasis added). Instead, the privilege is only waived when "a party, in the course of litigation, (1) makes an ***affirmative act*** injecting privileged materials into a proceeding, (2) thereby putting the materials at issue, (3) where application of the privilege would deny the opposing party access to information needed to effectively litigate its rights in the adversarial system." *United States v. Amlani*, 169 F.3d 1189, 1195 (9th Cir. 1999) (emphasis added); *see also Melendres*, 2015 WL 12911719 at *2.

Magistrate Judge Bowman found that "the State Defendants have *waived by implication* [not by an affirmative act] their attorney-client privilege as to" legal advice they received regarding the legality of the exclusion for gender reassignment surgery (the "Exclusion"). (Doc. 213 at 4:11–14 (emphasis added).) In reaching this decision, Magistrate Judge Bowman relied upon the misunderstanding that the Exclusion "exists in large part . . . because the State Defendants were advised that it is legal and nothing in the law requires the Plan to cover gender reassignment surgery." (*Id.*) Apparently, Magistrate Judge Bowman found that the State Defendants put the privileged documents at issue by asserting an advice of counsel defense.

The State Defendants, however, have never asserted that they relied on advice of counsel. Plaintiff and Magistrate Judge Bowman referenced the State Defendants' Answer and their Interrogatory responses in arguing and finding that the State relied upon the advice of counsel. However, neither the Answer nor the Interrogatory responses support such a finding.

The State Defendants' Answer nowhere mentions legal advice and the State Defendants did not assert an affirmative defense of advice of counsel. (*See generally* Doc. 89.)

Plaintiff's Interrogatory No. 1 requests "all reasons" why the State maintained the Exclusion. (Doc. 195-3, Ex. 3 at 2–3.) The State Defendants' response identifies several

reasons for the Exclusion. (*Id.* at 3.) Admittedly, one of those reasons was the State's determination that it was not required to provide such coverage under the then-existing law. (*Id.*) Magistrate Judge Bowman interpreted the State Defendants' assertion of the attorney-client privilege in response to Interrogatory No. 1 as an implicit acknowledgement that the State Defendants received legal advice in 2016 regarding the legality of the Exclusion and relied on advice of legal counsel. (Doc. 213 at 5:23–6:7.) However, the State Defendants' response to Interrogatory No. 1 nowhere states who provided legal advice, what the legal advice was, or even that the State relied on the legal advice to make its determination. (*Id.*) Indeed, as the Order acknowledges, the State Defendants' understanding of the law could be based on several non-privileged sources (such as newspaper articles). (*See* Doc. 213 at 5:23.) The documents produced in this matter show that the State in fact did receive interpretations of Affordable Care Act ("ACA") Rule 1557, and the legal impact of the Rule, from each of its insurance vendors, medical consultants, news sources, and public presentations. (*See, e.g.*, Declaration of Ryan Curtis in Support of Objection to Order Compelling Production ("Curtis Decl."), filed concurrently, Exhibit 1 (summarizing interpretations of Rule 1557 received from "Consultant and one Medical Vendor"); *id.* at Exhibit 2 (medical consultant explaining "what [Rule 1557] is proposing and how it will impact employers"); *id.* at Exhibit 3 (news publication detailing the scope of Rule 1557 and its "potential applicability to employers"); *id.* at Exhibit 4 (legal interpretation of Rule 1557 received from insurance vendor and including links to several news publications about Rule 1557); *id.* at Exhibits 5–7 (legal interpretations of Rule 1557 received from insurance vendors).) The State Defendants' response to Interrogatory No. 1 did not assert an advice of counsel defense and, thus, did not waive the attorney-client privilege.

Plaintiff's Interrogatory No. 7 requests an identification of any documents "considered, reviewed, or relied on" by the State Defendants in their decision to maintain the Exclusion. (Doc. 195-3, Ex. 3 at 7–8.) The Order cites to the fact that the State

Defendants specifically referenced legal memorandum in response to Interrogatory No. 7. (Doc. 213 at 4:23–5:1, 6:2–6.) As a result, the Order concludes, "the State Defendants' understanding of the law was based in large part on advice from counsel." (Doc. 213 at 6:6–7.) Again, however, the Order reads too much into the State Defendants' Interrogatory responses. The State Defendants' response to Interrogatory No. 7 does not state that the State "relied" on either of the privileged memorandums. (Doc. 195-3, Ex. 3 at 7–8.) Indeed, the response actually states only that the State "considered" the two memorandums. (*Id.*) The State Defendants' response further did not disclose any legal advice contained in either memorandum and did not indicate whether there even was a recommendation from legal counsel. (*Id.*) Moreover, the State Defendants' response to Interrogatory No. 7 explicitly identifies several non-privileged documents that were gathered from "insurers and other entities" regarding coverage for transgender healthcare benefits. (Doc. 195-3, Ex. 3 at 7–8.) Nothing in the State Defendants' response to Interrogatory No. 7 suggests that the State "primarily" or "in large part" relied on the advice of counsel for its understanding of the law. The State Defendants' response to Interrogatory No. 7 did not waive the attorney-client privilege.[1]

[1] Plaintiff's Motion also asserted that the State Defendants waived the privilege by identifying the attorneys who were present at certain meetings regarding the Exclusion. (*See* Doc. 195-3 at 4, 8.) The Order, however, does not address this argument and so the State Defendants will not address it in detail here. The State Defendants continue to assert that identifying attorneys consulted or present at a meeting does not waive the attorney-client privilege because such identification does not disclose the content of any underlying privileged communications. Indeed, the fact that counsel was consulted and the general subject matter discussed is not privileged in the first instance. *See, e.g.*, *Colton v. United States*, 306 F.2d 633, 636 (2d Cir. 1962); *State v. Alexander*, 108 Ariz. 556, 568 (1972) ("The privilege extends only to confidential [c]ommunications between the client and his attorney. Thus, the fact that the client has consulted an attorney, the dates and places of his visits, the identity of the client, and similar matters are outside the coverage of the privilege." (citation omitted)). As a matter of law and logic, disclosure of such non-privileged information does not constitute a waiver of privileged communications. *United States v. White*, 887 F.2d 267, 271 (D.C. Cir. 1989) ("An averment that lawyers have looked into a matter does not imply an intent to reveal the substance of the lawyers' advice. Where a defendant neither reveals substantive information, nor prejudices the government's case,

Quite plainly, neither the State Defendants' Answer nor their Interrogatory responses state: (1) what the legal advice was; (2) whether there was any recommendation from legal counsel; (3) whether they relied upon legal counsel's advice; (4) whether actions were based on or justified by legal advice; or (5) even which attorneys gave legal advice—outside legal counsel, in-house counsel at ADOA or the Governor's Office, or the Attorney General's Office. (Doc. 195-3, Ex. 3 at 3, 5, 7–8.) As such, the State Defendants did not affirmatively inject the legal advice into this matter or put the legal advice at issue. The State Defendants' Answer and Interrogatory responses did not waive the privilege.

Similarly, the deposition testimony of the State Defendants' witnesses did not waive the privilege. The Order relies on Ms. Isaacson's and Mr. Bender's statements that the "deciding factor" or "primary reason" for the State's decision to maintain the Exclusion was "that the law did not require gender reassignment surgery to be covered." (Doc. 213 at 5:1–9.) However, even the cited deposition testimony does not affirmatively state that the State relied on advice of counsel to make this determination. In her deposition, Ms. Isaacson testified that she did not make the decision to maintain the Exclusion; rather, Ms. Isaacson consulted with several persons, including "attorneys and the [G]overnor's office and the [D]irector's office." (Doc. 195-3, Ex. 6 at 18:8–17; *see also* Doc. 195-3, Ex. 6 at 80:10–15 ("Q: Did anyone other than counsel determine that surgery for gender dysphoria was not required by the law? A: I would say it was a combination of legal counsel and the [G]overnor's office and the [D]irector's office and the Attorney General's Office.").) Ms. Isaacson never testified that the State relied upon advice of counsel. Indeed, when asked what the "deciding factor" for maintaining the Exclusion was, Ms. Isaacson ***did not identify any legal advice***. (Doc. 195-3, Ex. 6 at 31:16–18.) As explained above, the State received interpretations of the legal requirements of ACA Rule 1557 from several non-attorneys,

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nor misleads a court by relying on an incomplete disclosure, fairness and consistency do not require the inference of waiver.").

including its insurance vendors and news sources. (Curtis Decl., Exhibits 1–7.) Similarly, Mr. Bender testified at his deposition that there were several reasons for the State's decision to maintain the Exclusion. (Doc. 195-3, Ex. 7 at 167:12–24.) Although Mr. Bender testified that the "primary reason" for maintaining the Exclusion was that the State was not required to cover it, Mr. Bender never even mentions that the State *consulted* legal counsel—never mind that the State *relied* on the advice of legal counsel. (*See generally* Doc. 195-3, Ex. 7.). As a result, the deposition testimony of the State Defendants' witnesses did not affirmatively inject the legal advice into this matter or put the legal advice at issue, and therefore did not waive the privilege.

II. DEPOSITION TESTIMONY FROM THE STATE DEFENDANTS' WITNESSES DID NOT WAIVE THE PRIVILEGE.

In addition to the fact that the deposition testimony did not assert an advice of counsel defense, the Order fails to address that neither Scott Bender nor former employee Marie Isaacson have authority to waive the attorney-client privilege. (*See generally* Doc. 213.)

When the client at issue is a corporation or other entity, only those with authority to speak for the entity can waive the privilege.[2] *Commodity Futures Trading Comm'n v. Weintraub*, 471 U.S. 343, 348 (1985). Only individuals "empowered to act on behalf of" the entity can waive the attorney-client privilege. *Id*. "[W]hen control of a corporation passes to new management, the authority to assert and waive the corporation's attorney-client privilege passes as well." *Id*. at 349.

No statement by Mr. Bender or Ms. Isaacson can waive the privilege because neither of them have authority to speak on behalf of the State Defendants. Mr. Bender is a Plan Administration Manager for the Arizona Department of Administration ("ADOA") (Doc.

[2] Under Arizona law, governmental entities are not different than corporations or other entities when it comes to the attorney-client privilege. *See* A.R.S. § 12-2234(B).

201-1, Ex. 15 at 16:20–17:12) and has no authority to speak on behalf of the ADOA or the State of Arizona (*see, e.g.*, Curtis Decl., Exhibit 8). In addition, Ms. Isaacson is a *former* employee of ADOA, who retired from employment with the State in 2018. (Doc. 201-1, Ex. 14 at 87:19–88:9.) As such, when she testified at her deposition in March 2021, she had no authority to speak on behalf of the State Defendants and could not waive the privilege. *Commodity Futures Trading*, 471 U.S. at 348–49; *Smith v. Ergo Sols., LLC*, No. CV 14-382 (JDB), 2017 WL 2656096, at *4 (D.D.C. June 20, 2017).

III. COMPELLING PRODUCTION OF THE PRIVILEGED DOCUMENTS VIOLATES IMPORTANT PUBLIC POLICY.

"The attorney–client privilege is the oldest of the privileges for confidential communications known to the common law." *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1981) (citing 8 J. Wigmore, Evidence § 2290 (McNaughton rev. 1961)). Its purpose is to "encourage full and frank communications between attorneys and their clients and thereby promote broader public interest in the observance of law and administration of justice." *Id*. The privilege is necessary because proper legal assistance can only be given when it is free from "consequences or the apprehension of disclosure." *Id.* (quoting *Hunt v. Blackburn*, 128 U.S. 464, 470 (1888)). The privilege applies equally to individuals, corporations, and other entities, including government entities. *Id*. at 389–90 (citing *United States v. Louisville & Nashville R. Co.*, 236 U.S. 318, 336 (1915)); *Commodity Futures Trading*, 471 U.S. at 348 (inanimate entities can assert the attorney-client privilege just as an individual can); A.R.S. § 12-2234(B).

Allowing the government to engage in privileged communications with legal counsel is uniquely important. As the Second Circuit explained,

> In the context of legal advice to government officials, the privilege furthers a culture in which consultation with government lawyers is accepted as a ***normal, desirable, and even indispensable*** part of conducting public business.

> Abrogating the privilege undermines that culture and thereby ***impairs the public interest.***

Am. C.L. Union v. Nat'l Sec. Agency, 925 F.3d 576, 589 (2d Cir. 2019) (internal quotations omitted) (emphasis added). The privilege applies with "special force" in the government context because the privilege encourages government officials formulating policies in the public interest to consult with counsel. *Modesto Irrigation Dist. v. Gutierrez*, 1:06-CV00453 OWWDLB, 2007 WL 763370 (E. D. Cal. Mar. 9, 2007).

Although the privilege is not absolute, the conditions in which the privilege can be overcome are extremely limited. As explained in the State Defendants' response to the Motion and above, none of those conditions are present here. Finding waiver here, where the State Defendants have disclosed only the fact that attorneys participated in the discussion but not the substance of the privileged communications, "would ill-serve the policies underlying the doctrine of implied waiver." *United States v. White*, 887 F.2d 267, 271 (D.C. Cir. 1989) (citing 8 J. Wigmore, Evidence § 2237 (McNaughton rev. 1961)). The attorney-client privilege is far too important to be deemed waived based on incomplete interpretations and implications. The State Defendants did not waive the privilege.

IV. THE ORDER IS UNCLEAR AND AMBIGUOUS.

Plaintiff's Motion apparently requested production of all 85 documents withheld by the State Defendants on the basis of the attorney-client privilege. (*See generally* Doc. 195; Doc. 205 at 8:8–9:5.) However, not all of the documents withheld by the State Defendants include advice regarding the legality of the Exclusion that the State Defendants considered in 2016 when the State made the decision to maintain the Exclusion. (*See* Doc. 195-3, Ex. 9.) Indeed, some of the documents sought discuss the instant litigation (*see, e.g.*, Doc. 195-3, Ex. 9 at Nos. 34–36 (2019 communications with prior litigation counsel Kate King), Nos. 39-40 (2019 communications with prior litigation counsel Kate King titled "Toomey v. State of AZ")), and still others primarily contain discussions regarding other topics (*see,*

e.g., Doc. 195-3, Ex. 9 at No. 1 ("Memorandum regarding leave, premiums, termination dates, and ACA Hours of Service")).

The Order grants Plaintiff's Motion and purports to compel the State Defendants to produce documents "they received on the legality of the Exclusion." (Doc. 213 at 6:1720.) The Order does not specify which documents the State Defendants must produce. (*See generally* Doc. 213.) The Order also does not identify the relevant timeframe of documents which the State Defendants must produce. (*See generally id.*) Without such parameters, the State Defendants are unable to determine how to comply with the Order. Clarification is needed in the event the Court decides not to overturn the Magistrate's Order.

Moreover, the Order is overbroad for the same reasons. As discussed, some of the 85 documents withheld by the State Defendants relate to discussions regarding to the instant litigation. (*See, e.g.*, Doc. 195-3, Ex. 9 at Nos. 34–36 & 39-40.) These documents may contain discussions about the validity of Plaintiff's claims and the legality of the Exclusion, and would, therefore, be compelled to be produced by the Order. However, these discussions bear absolutely no relation to the State's 2016 decision to maintain the Exclusion. Production of documents relating to the instant litigation would also materially harm the State Defendant's ability to defend itself and does not promote any "fairness principle."

Although no production should be required, the State Defendants request that, at most-if any, the Court compel production of the following attorney-client communications which relate to the legality of the Exclusion and were exchanged prior to the State's final decision to maintain the Exclusion in 2016: Nos. 3–5, 8–32, 51–60, 72, 75[3], 78–82, 113,

[3] Doc. 75 further contains a communication to the Governor's Office protected by executive communications privilege. The Governor's Office asserted the executive communications privilege and deliberative process privilege in this action, which assertions are the subject of a separately pending motion to compel. (*See* Doc. 202.) This communication within Doc. 75 should continue to be withheld or redacted until such time as the Court resolves Plaintiff's challenges to the Governor's Office's assertions of privilege.

126, 176–189, 191, 194–203, 207, 210–245, 224, 232. State Defendants noted this deficiency of Plaintiff's Motion in State Defendants' Response. (Doc. 201 at 17:12–19.) The Magistrate did not address this deficiency. It thus remains unclear what State Defendants must produce to comply with the Order. If the Court upholds the Order, clarification would be beneficial to all Parties and would prevent future disputes regarding the scope of the Order.

V. CONCLUSION

The documents sought by Plaintiff are protected by the attorney-client privilege and no action by the State Defendants waived the privilege. For these reasons, the State Defendants object to the Order and respectfully request that the Court deny Plaintiff's Motion to Compel.

Alternatively, the Court should clarify the Order to specify which documents it is compelling the State Defendants to produce.

DATED this 12th day of July, 2021.

FENNEMORE CRAIG, P.C.

By: *s/ Ryan Curtis*
Timothy J. Berg
Amy Abdo
Ryan Curtis
Shannon Cohan
Attorneys for Defendants State of Arizona, Andy Tobin, and Paul Shannon

18559470

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Attorneys for Defendants
State of Arizona, Andy Tobin, and Paul Shannon

UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona, *et al.*

Defendants.

No. 4:19-cv-00035

DECLARATION OF RYAN CURTIS IN SUPPORT OF DEFENDANTS STATE OF ARIZONA'S, ANDY TOBIN'S, AND PAUL SHANNON'S OBJECTIONS TO ORDER COMPELLING PRODUCTION

I, Ryan Curtis, submit this declaration under penalty of perjury pursuant to 28 U.S.C. § 1746 and declare as follows:

1. I am a Director at Fennemore Craig, P.C., am licensed to practice law in the State of Arizona, and am lead counsel for Defendants State of Arizona, Andy Tobin, and Paul Shannon (collectively, the "State Defendants").

2. I submit this declaration in support of the State Defendants' Objection to Order Compelling Production, filed concurrently.

3. I base this declaration on my personal knowledge and on information obtained in the course of the above-captioned matter.

4. Attached as **Exhibit 1 (filed under seal)** is a true and correct copy of State Defendants' produced document, Bates numbered AZSTATE.085480–085492.

5. Attached as **Exhibit 2** is a true and correct copy of State Defendants' produced document, Bates numbered AZSTATE.006174-006176.

6. Attached as **Exhibit 3** is a true and correct copy of State Defendants' produced document, Bates numbered AZSTATE.006113–006116.

7. Attached as **Exhibit 4** is a true and correct copy of State Defendants' produced document, Bates numbered AZSTATE.005674–005676.

8. Attached as **Exhibit 5** is a true and correct copy of State Defendants' produced document, Bates numbered AZSTATE.009210–009211.

9. Attached as **Exhibit 6** is a true and correct copy of State Defendants' produced document, Bates numbered AZSTATE.005656–005657.

10. Attached as **Exhibit 7 (filed under seal)** is a true and correct copy of State Defendants' produced document, Bates numbered AZSTATE.144044–144057.

11. Attached as **Exhibit 8** is a true and correct copy of excerpts of the Scott Bender Deposition Transcript, dated March 31, 2021.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED this 12th day of July, 2021.

By: Ryan C. Curtis
Ryan Curtis

18571381

INDEX OF EXHIBITS

DECLARATION OF RYAN CURTIS
IN SUPPORT OF DEFENDANTS STATE OF ARIZONA'S, ANDY TOBIN'S AND PAUL SHANNON'S OBJECTIONS TO ORDER COMPELLING PRODUCTION

Russell B. Toomey v. State of Arizona, et al.
4:19-CV-00035

Exh. No:	Description:
1	FILED UNDER SEAL
2	State Defs' produced document, Bates numbered AZSTATE.006174-006176
3	State Defs' produced document, Bates numbered AZSTATE.006113–006116
4	State Defs' produced document, Bates numbered AZSTATE.005674–005676
5	State Defs' produced document, Bates numbered AZSTATE.009210–009211
6	State Defs' produced document, Bates numbered AZSTATE.005656–005657.
7	FILED UNDER SEAL
8	A true and correct copy of excerpts of the Scott Bender Deposition Transcript, dated March 31, 2021.

EXHIBIT 1
FILED UNDER SEAL

EXHIBIT 2

Message

From: Chanelle Bergren [Chanelle.Bergren@azdoa.gov]
on behalf of Chanelle Bergren <Chanelle.Bergren@azdoa.gov> [Chanelle.Bergren@azdoa.gov]
Sent: 10/13/2015 8:47:28 PM
To: Marie Isaacson [Marie.Isaacson@azdoa.gov]
Subject: RE: UofA Question

I would also ask Buck review this topic as well. If what she is saying is true why are the carriers not covering the benefit on their commercial book?

From: Marie Isaacson
Sent: Friday, October 09, 2015 4:47 PM
To: Chanelle Bergren
Subject: FW: UofA Question

I just spoke with Leena in more detail. Basically if any of the vendors/TPA have a plan on the exchange, they are considered to be receiving federal dollars and can't have plans that discriminate against transgender – administer any plan that discriminates. So we would be forced to cover the benefit.

Also, we spoke about EGWP. Because we receive federal dollars through EGWP, our plan would also not be able to discriminate.

This is preliminary research and not an in depth analysis.

We can talk next week.

Marie

From: Bhakta, Leena [mailto:Leena.Bhakta@mercer.com]
Sent: Thursday, October 08, 2015 2:57 PM
To: Giammona, Chris; Marie Isaacson
Subject: RE: UofA Question

Marie,

I have been able to gather some more information about this proposed rule. The Department of HHS has proposed that if an entity in the health care business participates on the public exchange or otherwise is federally funded all of its activities may be subject to the non-discrimination provisions of ACA section 1557. The idea is, for example, if a TPA that is also an issuer offers a plan on a public exchange, the entire TPA may be subject to the law. So if the TPA of ADOA's self-funded plans also have fully insured options they sell on the exchange, ADOA would be impacted by these proposed rules.

Note that the proposed rule does not require plans to cover any particular benefit or service, but it cannot have explicit categorical exclusions in coverage for any of the above classes (sex, gender or gender identity). As an example, categorical exclusions in coverage for health care services related to gender transition, HHS FAQs say, are facially discriminatory. The regulations address in particular two areas of discrimination in health care programs and activities – discrimination against individuals based on sexual identity (which it views as a type of sex discrimination) and failing to offer services to non-English speakers. Obviously these are proposed rules and a lot could change. Hope this helps.

Leena

From: Giammona, Chris
Sent: Thursday, October 08, 2015 1:11 PM
To: Marie Isaacson
Cc: Bhakta, Leena
Subject: RE: UofA Question

Marie

Here is the link to the proposed rule

https://www.federalregister.gov/articles/2015/09/08/2015-22043/nondiscrimination-in-health-programs-and-activities

Leena is checking with our internal Washington Resource Group for Mercer's POV and possible comments.

Chris

Chris Giammona, Partner

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M: +1 949 870 8721
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www.mercer.com | Mercer (US) Inc.

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MERCER MAKE TOMORROW, TODAY

From: Marie Isaacson [mailto:Marie.Isaacson@azdoa.gov]
Sent: Thursday, October 08, 2015 11:32 AM
To: Giammona, Chris
Subject: FW: UofA Question

Good morning Chris. UA indicated that there is a new proposed ACA rule open for comment now through November, 2015 regarding mandatory coverage for transgender benefits. Can you tell me what the rule is proposing and how it will impact employers?

Please let me know if you want to discuss this further or need additional information.

Thank you,
Marie

From: Chanelle Bergren
Sent: Friday, September 25, 2015 2:21 PM
To: Marie Isaacson
Cc: Nicolette A Schultz
Subject: RE: UofA Question

Mercer confirmed there are no current laws which require a plan to cover transgender benefits. As a result, the plan is not discriminating when excluding benefit coverage. The majority of their clients do not offer transgender coverage. The

State of California, State of Oregon, State of Colorado, State of Washington and the University of California do offer transgender benefits. I have provided links to applicable information below.

http://ucnet.universityofcalifornia.edu/forms/pdf/uc-care-booklet.pdf
http://www.plu.edu/human-resources/wp-content/uploads/sites/141/2015/03/transgender-benefits-article.pdf
https://www.calpers.ca.gov/docs/2016-anthem-select-hmo-evidence-coverage.pdf

Chanelle Bergren
Plan Administration Manager
ADOA- Benefit Services Division I State of Arizona
100 N.15th Ave Suite 103, Phoenix, AZ 85007
p: 602-542-0395 I m: 602-689-7168 I f: 602-542-4048
Chanelle.Bergren@azdoa.gov
http://benefitoptions.az.gov/

How am I doing? Please take a few moments to answer a few questions.
https://www.surveymonkey.com/r/BenPlanAdmin

From: Marie Isaacson
Sent: Friday, September 25, 2015 8:34 AM
To: Chanelle Bergren
Cc: Nicolette A Schultz
Subject: Re: UofA Question

The claim will be the plan is discriminatory. What would be our response? Is this standard to exclude?

Sent from my iPhone

On Sep 24, 2015, at 4:12 PM, Chanelle Bergren <Chanelle.Bergren@azdoa.gov> wrote:

We cover all standard benefits but currently exclude the following benefits:

Transgender Surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

Chanelle Bergren
Plan Administration Manager
ADOA- Benefit Services Division I State of Arizona
100 N.15th Ave Suite 103, Phoenix, AZ 85007
p: 602-542-0395 I m: 602-689-7168 I f: 602-542-4048
Chanelle.Bergren@azdoa.gov
http://benefitoptions.az.gov/

How am I doing? Please take a few moments to answer a few questions.
https://www.surveymonkey.com/r/BenPlanAdmin

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information in this e-mail and its attachments. If you have received this e-mail in error, please immediately notify the person named above by reply e-mail, and then delete the one you received.

EXHIBIT 3

Message

From: Rodrigues, Helena A - (hrodrigu) [hrodrigu@email.arizona.edu]
on behalf of Rodrigues, Helena A - (hrodrigu) <hrodrigu@email.arizona.edu> [hrodrigu@email.arizona.edu]
Sent: 11/20/2015 1:26:45 PM
To: Marie.Isaacson@azdoa.gov
Subject: FW: HHS Issues Proposed Rule on ACA Section 1557 Nondiscrimination Rules Which May Affect Certain Employer-Sponsored Plans

Hi, Marie:

I found this as a helpful "summary." I highlighted the section on effective date.

Helena

From: Wilson, Staci R - (staciw)
Sent: Thursday, November 19, 2015 4:49 PM
To: Rodrigues, Helena A - (hrodrigu) <hrodrigu@email.arizona.edu>
Subject: FW: HHS Issues Proposed Rule on ACA Section 1557 Nondiscrimination Rules Which May Affect Certain Employer-Sponsored Plans

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From: Meyer, Michelle K - (mmeyer)
Sent: Thursday, November 19, 2015 4:12 PM
To: Wilson, Staci R - (staciw); Azuelo, Linda K - (azuelo)
Cc: Salazar, Nicole J - (hinzen)
Subject: FW: HHS Issues Proposed Rule on ACA Section 1557 Nondiscrimination Rules Which May Affect Certain Employer-Sponsored Plans

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From: Eye on Washington [mailto:EOW@adp.com]
Sent: Thursday, November 19, 2015 3:15 PM
To: Meyer, Michelle K - (mmeyer)
Subject: HHS Issues Proposed Rule on ACA Section 1557 Nondiscrimination Rules Which May Affect Certain Employer-Sponsored Plans

If you are having trouble reading this email, read the online version.

HHS Issues Proposed Rule on ACA Section 1557 Nondiscrimination Rules Which May Affect Certain Employer-Sponsored Plans

The Department of Health and Human Services (HHS) recently published a proposed rule broadly prohibiting discrimination in health programs and related activities that receive funding from the HHS. The proposed rule directly affects health insurers, health care providers (including pharmacies and health clinics), and some employer-sponsored group health plans.

Specifically, the Office of Civil Rights (OCR) at HHS published a sweeping proposed rule implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA). ("Nondiscrimination in Health Programs and Activities," Proposed Rule, 80 Fed. Reg. 54172-54221.) The proposed rule broadly prohibits discrimination in health programs and activities on the basis of race, color, national origin, sex, age, or disability. Notably, Section 1557 is the first law to prohibit sex discrimination in health care programs, and the proposed rule includes significant requirements related to transgender individuals and the treatment of gender dysphoria. The proposed rule also includes requirements for language assistance for individuals with limited English proficiency (LEP) and accessibility and effective communication for individuals with disabilities.

In the proposed rule, HHS has interpreted the statutory requirements extremely broadly, potentially sweeping entire entities into the scope of Section 1557 when even only one plan or program receives any federal funds from HHS. Importantly for employers, this means that even self-funded plans that utilize health insurers as third-party administrators (TPAs) may be affected.

Background on Section 1557 and Proposed Rule

ACA Section 1557 provides generally that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination based on race, color, national origin, sex, age, or disability, under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA or its amendments.

The proposed rule generally applies to any health program or activity, any part of which receives funding from HHS, health programs and activities administered by HHS, which would include health insurers participating in the Federal Marketplace, and entities established under Title I of the ACA, which would include State-based Marketplaces. The proposed rule defines "federal financial assistance" to specifically include subsidies for individuals receiving coverage through the Marketplaces. For health insurers that receive federal financial assistance, the rule appears to apply to the entire entity, so that health insurance products offered through the Marketplace, outside the Marketplace in the individual or group health insurance markets, and by the health insurer as a TPA for self-funded employer-sponsored group health plans would appear to be subject to the proposed rule.

Potential Applicability to Employers

For health insurers that receive federal financial assistance, the proposed rule appears to apply to health insurance offered to employers through the group health insurance markets. It would also appear to apply to the health insurer when it acts as a TPA for an employer-sponsored group health plan, even if the plan is self-funded. If a TPA's Section 1557 obligations apply to its self-funded clients, this rule will create an incentive for employers to self-fund using TPAs that do not receive federal funds.

Prohibited Discrimination

The proposed rule prohibits discrimination based on an individual's race, color, national origin, sex, age, or disability under a health program or activity. Under the rule, discriminatory actions specifically include denying or limiting health coverage, denying a claim, employing marketing or benefit designs, and imposing additional cost-sharing on the basis of an individual's race, color, national origin, sex, age, or disability, and automatically excluding coverage for all health services related to gender transition. The proposed rule does not provide any specific examples of benefit designs that would be discriminatory. However, one of the key compliance issues is likely to be the inclusion/exclusion and placement on formularies of drugs that treat conditions prevalent for protected individuals.

- Sex Discrimination: The proposed rule also makes clear that discrimination based on sexual orientation is prohibited under Section 1557. The proposed rule provides that individuals may not be subject to discrimination based on

sexual stereotyping or gender identity. For example, under the rule (1) individuals cannot be denied health care or health coverage based on their sex, including their gender identity; (2) individuals must be treated consistent with their gender identity, including in access to facilities; (3) sex-specific health care cannot be denied or limited only because the person seeking such services identifies as belonging to another gender; and (4) explicit categorical exclusions in coverage for all health services related to gender transition are facially discriminatory. It is not uncommon for large employers to limit gender identity coverage, and as mentioned previously, it is possible that self-funded health plans that use health insurance issuers as TPAs may be subject to Section 1557.

- Language Services and Auxiliary Aids and Services: The proposed rule includes requirements for language assistance for LEP individuals and provides guidance regarding the provision of language services, such as oral interpreters and written translations. In determining what the general standard requires, the rule provides that this will be a flexible standard and will be evaluated on a case-by-case basis, taking into consideration various factors, such as the nature of the communication, how often the entity encounters individuals who speak the language at issue, and the resources of the entity. Under the proposed rule, entities would be required to post a notice of consumer rights providing information about communication assistance, and post taglines in the top 15 languages spoken by individuals with LEP nationally, indicating the availability of such assistance. OCR will provide a sample notice and translated taglines, and will translate the notice into 15 languages.

For individuals with disabilities, the rule includes requirements for the provision of auxiliary aids and services, including alternative formats for written information and sign language interpreters. This requirement also includes a notice that entities must post that provides information about these services.

Private Right of Action

The proposed rule provides for a private right of action (meaning that individuals have the ability to file a lawsuit under Section 1557) and damages for violations of Section 1557. The rule is not clear about administrative exhaustion, except for age discrimination claims; OCR will require administrative exhaustion for claims of age discrimination.

Effective Date

OCR proposes that the rule will be effective 60 days after being finalized. This would be a very tight timeline for employer plans that may be indirectly subject to Section 1557 through health insurance issuers receiving Federal financial assistance acting as their TPA.

The proposed rule can be found at http://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-22043.pdf.

ADP Compliance Resources

ADP maintains a staff of dedicated professionals who carefully monitor federal and state legislative and regulatory measures affecting employment-related human resource, payroll, tax and benefits administration, and help ensure that ADP systems are updated as relevant laws evolve. For the latest on how federal and state tax law changes may impact your business, visit the ADP *Eye on Washington* Web page located at www.adp.com/regulatorynews.

ADP is committed to assisting businesses with increased compliance requirements resulting from rapidly evolving legislation. Our goal is to help minimize your administrative burden across the entire spectrum of employment-related payroll, tax, HR and benefits, so that you can focus on running your business. This information is provided as a courtesy to assist in your understanding of the impact of certain regulatory requirements and should not be construed as tax or legal advice. Such information is by nature subject to revision and may not be the most current information available. ADP encourages readers to consult with appropriate legal and/or tax advisors. Please be advised that calls to and from ADP may be monitored or recorded.

If you have any questions regarding our services, please call 855-466-0790.

ADP, LLC
1 ADP Boulevard, Roseland, NJ 07068
adp.com
Updated November 19, 2015

EXHIBIT 4

Message

From: Scott Bender [Scott.Bender@azdoa.gov]
on behalf of Scott Bender <Scott.Bender@azdoa.gov> [Scott.Bender@azdoa.gov]
Sent: 6/9/2016 2:46:29 PM
To: Marie Isaacson [Marie.Isaacson@azdoa.gov]; Elizabeth Schafer [Elizabeth.Schafer@azdoa.gov]
Subject: FW: Final rule - enhanced protection for transgender individuals

Here's UHC's interpretation of the recent ruling, more info to follow next week.

From: Martin, Stephanie A [mailto:stephanie_martin@uhc.com]
Sent: Thursday, June 09, 2016 12:12 PM
To: Scott Bender <Scott.Bender@azdoa.gov>
Cc: Gallegos, Heather K <heather_gallegos@uhc.com>
Subject: RE: Final rule - enhanced protection for transgender individuals

Hi Scott,

I am anticipating that we will have more information related to our position as an Insurer next week.

With that said, I can tell you the following information was released within UnitedHealthare yesterday related to the Non-Discrimination Act and below information is specific to transgender benefits:

Expanded Protection for Transgender Individuals
Covered entities are not required to cover any specific item or service for transgender individuals. Categorical coverage exclusions or limitations for all health services related to gender transition are not allowed. Individuals may not be excluded from health programs and activities for which they are otherwise eligible based on their gender identity.

Covered entities may use nondiscriminatory limitations or restrictions on coverage. The same neutral, nondiscriminatory criteria used for other coverage determinations must be used when addressing gender transition. If certain elective procedures beyond those considered medically necessary are covered, then the same standards must apply to coverage of comparable procedures for gender transition.

The Office of Civil Rights will not second-guess a covered entity's neutral nondiscriminatory application of evidence-based criteria used to make medical necessity or coverage determinations. But it cautions that covered entities must use a nondiscriminatory process to determine whether a particular health service is medically necessary or otherwise meets applicable coverage requirements.

Some procedures are only appropriate for individuals of one sex and, therefore, coverage is not required for individuals for whom the procedure isn't applicable. Coverage for health services must be appropriately provided to individuals regardless of their sex assigned at birth, gender identity or recorded gender.

Section 1557 and ASO Employers
ASO employers' obligations under Section 1557 are determined independent of the status of the third-party administrator as a covered entity. The final rule acknowledges that third-party administrators are not responsible for the benefit design for the ASO plans they administer. As such, each ASO employer will need to evaluate their status as a covered entity under Section 1557 and other relevant laws such as Title VII of the Civil Rights Act.

Lastly, another item we will be monitoring closely is a lawsuit that was filed by the American Civil Liberties Union (ACLU) on Monday, June 6th against **Dignity Health** because it denies transition related healthcare under its benefits plan.

Listed below is a link to an ACLU announcement specific to a lawsuit filed by an employee of Dignity Health:
https://www.aclu.org/news/aclu-challenges-major-health-systems-denial-insurance-transgender-employee

Below is another link to the same story published by Reuters:
http://www.reuters.com/article/health-transgender-idUSL1N1900CZ

There are also a number of local news stories on this same issue as well- Fox 10, AZ Family (channel 3), KJZZ (NPR), Phoenix Business Journal.

I will provide additional information as it is released to us as well as updates to the ACLU/Dignity Health case.

Let us know if you have any questions.

Thanks,
Stephanie

Stephanie A. Martin
Strategic Client Executive, Client Management
UnitedHealthcare National Accounts
1 E. Washington St., Suite 1700, AZ009-17TE, Phoenix, AZ 85004
(w) 602-255-8497 (m) 602-770-4711
stephanie_martin@uhc.com

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From: Gallegos, Heather K
Sent: Thursday, June 09, 2016 6:50 AM
To: Scott Bender
Cc: Martin, Stephanie A; Gallegos, Heather K
Subject: RE: Final rule - enhanced protection for transgender individuals

Scott,
I wanted to acknowledge receipt and advise we are currently looking into this further. We will provide follow up once we have additional information.

Thanks,
Heather

Heather K. Gallegos | Senior Account Manager, Client Management
UnitedHealthcare
Government, Labor & Education
(office) 602.255.8525 (cell) 602.451.9867
(email) Heather_K_Gallegos@uhc.com

***Our* United Culture. The way forward.**
■ Integrity ■ Compassion ■ Relationships ■ Innovation ■ Performance

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From: Scott Bender [mailto:Scott.Bender@azdoa.gov]
Sent: Wednesday, June 08, 2016 6:17 PM
To: Muth, Ken; Severns, Colette; Emmons, Erica 654; Eveleth, Ray G; Dash, Jay A; Gallegos, Heather K
Subject: Final rule - enhanced protection for transgender individuals

Hi all,

Now that the HHS has issued a final rule on the nondiscrimination in health programs under the ACA, we need some guidance as to whether our plans as they exist will be compliant as of the effective date of July 18, 2016. The ruling expands protection for transgender individuals with respect to accessibility for health services that may not be denied or limited due to an individuals assigned sex at birth, gender identity or recorded gender. What's not clear is if our plans must now cover reassignment surgery, or other treatments required during a transition. Please advise how your organization is treating this ruling and how specifically the ADOA plans are impacted.

Thanks
Scott

Scott Bender
Plan Administration Manager
ADOA – Benefit Services Division | State of Arizona
100 North 15th Avenue, Suite 260, Phoenix, AZ 85007
p: 602-542-4958 | f: 602-542-4048 | Scott.Bender@azdoa.gov
http://benefitoptions.az.gov/

ADOA-HRD

EXHIBIT 5

Message

From: Emmons, Erica 654 [Erica.Emmons@Cigna.com]
on behalf of Emmons, Erica 654 <Erica.Emmons@Cigna.com> [Erica.Emmons@Cigna.com]
Sent: 6/15/2016 11:41:41 AM
To: Scott Bender [Scott.Bender@azdoa.gov]
CC: Maddalena, Diana M 646 [Diana.Maddalena@Cigna.com]
Subject: RE: Final rule - enhanced protection for transgender individuals

Hi Scott –
I sent your inquiry to Cigna's healthcare legislation team. Below is Cigna's response at this point:

Employers should be aware of whether they are considered a "covered entity" as defined in the final regulation. Employers such as hospitals or other provider types that receive Federal financial assistance are impacted by the rule in its entirety (that would include requirements for language assistance, disability accessibility - including in connection with building and facilities, and assuring equal access to services for persons in a protected class). Employers are also impacted if they operate a health program or activity which, in any part, receives Federal financial assistance or funding (examples include Medicare Part A, student health plans, advanced premium tax credits, and many more).

For the "average" employer, the primary impact will be the requirement to eliminate categorical exclusions or limitations for all health services related to gender transition. ASO clients, for whom Cigna is the TPA, will be responsible for making their own determination of how they will handle coverage or exclusion for gender transition.

Should an ASO client establish a benefit design that is defined as discriminatory – it either contains a categorical exclusion, or contains a difference in cost sharing (like a lifetime maximum or a higher copay) for gender transition services, they may be subject to investigation by the EEOC for such practices. These issues will not fall under the enforcement responsibilities of the Office of Civil Rights in connection with this Nondiscrimination rule, but may be referred to the EEOC for enforcement. Employers who have insured coverage with Cigna will see their plans modified at the first renewal on and after 1/1/2017 – to remove any outright exclusion for gender transition.

The industry, as a whole, is in the very early stages of analyzing this wide-ranging regulation, and additional clarification may be provided as that process continues.

Erica Emmons | Strategic Account Executive | Government and Education | Cigna | 5310 East High Street, Suite 200 | Phoenix, AZ 85054 | Direct: 480.426.6761 | Mobile: 480.622.0899 | erica.emmons@cigna.com

From: Scott Bender [mailto:Scott.Bender@azdoa.gov]
Sent: Wednesday, June 08, 2016 6:17 PM
To: Muth, Ken; Severns, Colette; Emmons, Erica 654; Eveleth, Ray G; Dash, Jay A; heather_k_gallegos@uhc.com
Subject: Final rule - enhanced protection for transgender individuals

Hi all,

Now that the HHS has issued a final rule on the nondiscrimination in health programs under the ACA, we need some guidance as to whether our plans as they exist will be compliant as of the effective date of July 18, 2016. The ruling expands protection for transgender individuals with respect to accessibility for health services that may not be denied or limited due to an individuals assigned sex at birth, gender identity or recorded gender. What's not clear is if our plans must now cover reassignment surgery, or other treatments required during a transition. Please advise how your organization is treating this ruling and how specifically the ADOA plans are impacted.

Thanks
Scott

Scott Bender
Plan Administration Manager
ADOA – Benefit Services Division | State of Arizona
100 North 15th Avenue, Suite 260, Phoenix, AZ 85007
p: 602-542-4958 | f: 602-542-4048 | Scott.Bender@azdoa.gov
http://benefitoptions.az.gov/

ADOA-HRD

EXHIBIT 6

Message

From: Scott Bender [Scott.Bender@azdoa.gov]
on behalf of Scott Bender <Scott.Bender@azdoa.gov> [Scott.Bender@azdoa.gov]
Sent: 9/2/2016 9:59:36 AM
To: Marie Isaacson [Marie.Isaacson@azdoa.gov]
Subject: FW: Final rule - enhanced protection for transgender individuals

Hi Marie, for your meeting this morning, Aetna has confirmed this is the latest guidance from them on the Transgender benefits issue. No additional updates have been received since 6/22.

Thanks
Scott

From: Eveleth, Ray G [mailto:EvelethR@aetna.com]
Sent: Wednesday, June 22, 2016 12:58 PM
To: Scott Bender <Scott.Bender@azdoa.gov>
Cc: Dash, Jay A <DashJ@aetna.com>
Subject: RE: Final rule - enhanced protection for transgender individuals

Hi Scott,

From Aetna legal:

Generally, employer self-funded plans are not affected. Exceptions relate to receipt of federal funding. If the employer does need to make a change, it would apply as of first plan year starting on or after Jan 1, 2017.

Employer Liability for Discrimination in Employee Health Benefit Programs

The final rule generally does not apply to the employer-employee relationship. However, a covered entity (a health program or activity that receives federal financial assistance) may be subject to the rules with respect to its own "employee health benefit program" under certain circumstances.

➢ **Employee health benefit program** means health benefits or health insurance coverage, an employer- sponsored or provided wellness program (whether or not offered with a group health plan), an employer- provided health clinic, and long-term care coverage or insurance (provided for the benefit of an employer's employees).

First, if the entity is principally engaged in providing or administering health services, health insurance coverage, or other health coverage, the covered entity shall be liable for violations of this rule with respect to its employee health benefit program. For example, if a health insurance issuer provides health benefits to its employees, it will be subject to section 1557 not only for the coverage it offers to insureds, but also for the health benefits it provides to its employees.

Second, if the entity received federal financial assistance, a primary objective of which is to fund the entity's employee health benefit program, the covered entity shall be liable for violations of this rule with respect to its employee health benefit program. For example, if an entity receives federal financial assistance from HHS specifically designated to support its employee wellness program, section 1557 will apply to the entity's administration of that wellness program.

Third, if the entity is not principally engaged in providing or administering health services, health insurance coverage, or other health coverage, but operates a health program or activity (which is not an employee health benefit program) that receives federal financial assistance; except that the entity is liable under this part with regard to the provision or administration of an employee health benefit program, but only with respect to the employees in that health program or activity. For example, a pharmacy housed within a department store would be subject to section 1557, but only with respect to the employees in the pharmacy.

42 CFR § 92.208 Employer liability for discrimination in employee health benefit programs.

A covered entity that provides an employee health benefit program to its employees and/or their dependents shall be liable for violations of this part in that employee health benefit program only when:

(a) The entity is principally engaged in providing or administering health services, health insurance coverage, or other health coverage;

(b) The entity receives Federal financial assistance a primary objective of which is to fund the entity's employee health benefit program; or

(c) The entity is not principally engaged in providing or administering health services, health insurance coverage, or other health coverage, but operates a health program or activity, which is not an employee health benefit program, that receives Federal financial assistance; except that the entity is liable under this part with regard to the provision or administration of employee health benefits only with respect to the employees in that health program or activity.

Be well,

Ray Eveleth
Senior Account Executive
Aetna Public & Labor Sector
4500 E. Cotton Center Blvd., Phoenix, AZ 85040
T 602-659-9238
C 480-220-5452
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aetna®

This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna

EXHIBIT 7
FILED UNDER SEAL

EXHIBIT 8

In The Matter Of:

Toomey vs.

State of AZ

Scott Bender, Videotaped

March 31, 2021

Glennie Reporting Services, LLC

1555 East Orangewood Avenue

Phoenix, Arizona 85020

602.266.6535 Office 877.266.6535 Toll Free

www.glennie-reporting.com office@glennie-reporting.com

Original File 033121SB.txt

Min-U-Script®

SCOTT BENDER,

called as a witness herein, having been first duly sworn by the Certified Reporter to speak the whole truth and nothing but the truth, was examined and testified as follows:

THE VIDEOGRAPHER: Please begin when ready.

E X A M I N A T I O N

BY MR. WALL:

Q. Good morning, Mr. Bender. How are you?

A. I'm doing well, thanks. How are you?

Q. I'm doing all right.

Would you please state your full name and address for the record?

A. Yes. Scott Patrick Bender. My address is 893 South Gardner Drive, Chandler, Arizona 85224.

Q. And, Mr. Bender, are you being represented by Mr. Ryan Curtis today at this deposition?

A. Yes.

Q. And have you ever been deposed before?

A. No.

Q. Have you ever testified at trial?

A. No.

Q. Okay. So I'm going to go over some ground

A. We understand that's part of the process, but, you know, whatever that committee feels is best for the State is -- or for the health plans is not necessarily our driving concern.

Q. What about the opinion of the Arizona Governor's Office?

A. The director of ADOA reports to the governor's office, and as part of the ADOA, we do as well. So they are the decision makers in this, so that is obviously considered.

Q. So any change to the plan had to be approved by the Arizona Governor's Office?

A. Correct.

Q. Are there any changes to the plan that the director of the ADOA can make his or herself?

A. Yeah, I think to some -- to some degree, the director of ADOA has -- has quite a bit of latitude. If there's small changes, you know, the selection of vendors is -- is fairly, usually, fairly simple. And that's typically not something that has to be approved by the governor's office. There's a procurement process for that.

Q. Is there anything else that the director of the ADOA could approve without the governor office's approval?

STATE OF ARIZONA)
COUNTY OF MARICOPA)

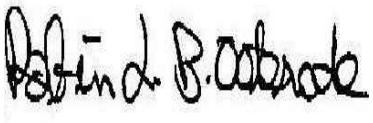
BE IT KNOWN that the foregoing proceedings were taken before me; that the witness before testifying was duly sworn by me to testify to the whole truth; that the foregoing pages are a full, true, and accurate record of the proceedings all done to the best of my skill and ability; that the proceedings were taken down by me in shorthand and thereafter reduced to print under my direction.

[X] Review and signature was requested.

[ ] Review and signature was waived.

[ ] Review and signature not required.

I FURTHER CERTIFY that I have complied with the ethical obligations set forth in the ACJA 7-206(F)(3) and ACJA 7-206(J)(1)(g)(1) and (2). Dated at Phoenix, Arizona, this 13th day of April, 2021.



ROBIN L. B. OSTERODE, RPR
CA CSR No. 7750
AZ CR No. 50695

* * * * *

I CERTIFY that Glennie Reporting Services, LLC, has complied with the ethical obligations set forth in ACJA 7-206(J)(1)(g)(1) through (6).

GLENNIE REPORTING SERVICES, LLC
Registered Reporting Firm
Arizona RRF No. R1035

EXHIBIT 8

Victoria Lopez – 330042
Christine K Wee – 028535
ACLU FOUNDATION OF ARIZONA
3707 North 7th Street, Suite 235
Phoenix, Arizona 85014
Telephone: (602) 650-1854
Email**:** vlopez@acluaz.org
Email**:** cwee@acluaz.org

Joshua A. Block*
Leslie Cooper*
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
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Admitted Pro hac vice

Attorneys for Plaintiff Russell B. Toomey

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Russell B. Toomey,

Plaintiff,

v.

State of Arizona; Arizona Board of Regents, D/B/A University of Arizona, a governmental body of the State of Arizona; et al.,

Defendants.

Case No.19-cv-00035-TUC-RM (LAB)

REPLY MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF'S SECOND MOTION FOR ENTRY OF AN ORDER COMPELLING THE PRODUCTION OF DOCUMENTS

Plaintiff, Dr. Russell B. Toomey, on behalf of himself and the certified Classes ("Plaintiff"), through the undersigned counsel, pursuant to Federal Rule of Civil Procedure 37 and Arizona Local Rule 7.2, hereby submits this memorandum of law in further support of his Second Motion to Compel (the "Motion" or "Mot.") (Doc. 195) and in reply to Defendants State of Arizona's, Andy Tobin's, And Paul Shannon's Opposition To Plaintiff's Second Motion To Compel ("Opposition" or "Opp.") (Doc. 201).

THE COURT SHOULD GRANT PLAINTIFF'S MOTION TO COMPEL

State Defendants fail to rebut that they have waived attorney-client privilege with respect to legal advice they received concerning the legality of the Exclusion. The Opposition's false, revisionist recount of State Defendants' written discovery responses, mischaracterization of witness testimony, and *ad nauseum* recitation of largely irrelevant

facts are all misdirection. At bottom, State Defendants have waived the privilege by putting at-issue legal advice they received regarding the Exclusion, and attempting to use that advice as both a sword and a shield. Alternatively, State Defendants have waived the privilege by their consistent, affirmative, and selective disclosure of its content.

Finally, State Defendants' argument that the Motion is deficient because it does not adequately list the documents sought is both factually inaccurate and unsupported by law.

ARGUMENT

I. THE STATE DEFENDANTS WAIVED ATTORNEY-CLIENT PRIVILEGE BY ASSERTING THAT ADVICE OF COUNSEL IS A NONDISCRIMINATORY "REASON[] WHY" THEY HAVE MAINTAINED THE EXCLUSION

State Defendants admit that the attorney-client privilege can be waived where a party's "subjective intent" is at issue, and a party justifies its decisions or actions based on the "legal advice it received." (Opp. 4) State Defendants otherwise fail to cite any authority rebutting the soundness of the this principle, commonly known as the "at-issue doctrine." State Defendants instead dispute the applicability of the doctrine here. (Opp. 4-12) As this Court has consistently held, State Defendants' intent remains a live and critical issue in the case. (Doc. 134 at 9; Doc 187 at 5) State Defendants attempt to explain away their consistent, affirmative, and selective assertion of the legal advice received about the legality of the Exclusion to justify its maintenance. (*See* Opp. 4–12) Each of their explanations fails.

First, State Defendants disingenuously suggest that their interrogatory responses neither affirmatively nor impliedly assert an advice of counsel defense. (Opp. 4–9) State Defendants argue, incredibly, that their responses merely "disclose[] that legal counsel was consulted" and that the responses do not say "what the legal advice was," "whether [State Defendants] relied upon legal counsel's advice" or "whether actions were based on or justified by legal advice." (Opp. 4) State Defendants' revisionist take on their own

discovery responses makes no sense, and the Court need only read the interrogatories to which they responded to see why.

Preliminarily, in their Answer to Plaintiff's Complaint, State Defendants averred that the Exclusion is lawful because it was maintained for non-discriminatory reasons. (Doc 89 at 28, J) Accordingly, Plaintiff's Interrogatory No. 1 asked State Defendants to "[i]dentify and describe all *reasons why* the State of Arizona's self-funded health plan controlled by the [ADOA] excludes coverage for 'gender reassignment surgery[.]'" (Doc. 195-3, Ex 4 at No. 1 (emphasis added)) The interrogatory does not ask State Defendants to "provide[] a backdrop" to the ADOA's decision-making in 2016 (Opp. 5) or to "explain[] the context" behind the decision to maintain the Exclusion (Opp. 8). Rather, it quite clearly seeks the *reasons why* the Exclusion was put into place, if not for discriminatory purposes. State Defendants responded that the Exclusion was maintained "*because* the State concluded, under the law, that it was not legally required" to cover gender reassignment surgery. (Doc 195-3, Ex 5 No. 1 (emphasis added)) The plain words of this response put forth legal advice or understanding of legality as a basis for the Exclusion.

Plaintiff's Interrogatory Nos. 4 and 7 asked State Defendants to (1) "[i]dentify all persons who participated in formulating, adopting, maintaining, reviewing, approving, or deciding to continue the exclusion" (No. 4), and to (2) "[i]dentify all research, studies, data, reports, publications, testimony, or other documents considered, reviewed, or relied on by Defendants relating to the Challenged Exclusion" (No. 7). (Doc. 195-3, Ex. 4 Nos. 4, 7) State Defendants responded to Interrogatory No. 4 by pointing to, among others, at least three lawyers, including Michael Liburdi, John Fry, and Nicole A. Ong. (Doc. 195-3, Ex. 5 No. 4) In response to Interrogatory No. 7, State Defendants identified only two specific documents: memoranda, by and between Ms. Isaacson and legal counsel that are allegedly "covered by the attorney-client privilege," which are the subject of the

instant Motion.1 (Doc. 195-3, Ex. 5 No. 7) It is unambiguous, especially in light of their response to Interrogatory No. 1, that State Defendants were affirmatively asserting their reliance on legal advice, including the legal advice reflected in these memoranda, to support an allegedly non-discriminatory basis for the Exclusion. This is further supported by testimony of State witnesses, who have affirmed that legal advice was not just a consideration, but the "primary reason" for maintaining the Exclusion. (Mot. 5)

Second, State Defendants contend that they "have not asserted advice of counsel as an affirmative defense in [their] Answer" or otherwise. (Opp. 4) State Defendants recognize, however, that the at-issue doctrine may be invoked due to both formal and informal assertions of such defenses. (*See* Opp. 4 ("advice of counsel defense need not be asserted in a pleading")) Courts examine and scrutinize the substantive claims and defenses of the parties when considering the applicability of the doctrine, and several have applied it when defenses such as the "advice of counsel" were implicitly made through affirmative acts occurring in discovery. *See Chevron Corp. v. Pennzoil Co*., 974 F.2d 1156, 1162 (9th Cir. 1992); *Melendres v. Arpaio*, CV-07-2513-PHX-GMS, 2015 WL 12911719, at *2-3 (D. Ariz. May 14, 2015). In *Chevron*, the at-issue doctrine was implicated "[d]uring the course of discovery," after the defendant corporation submitted a witness declaration maintaining that the investment in dispute had been reasonable "based upon" legal considerations, and further, was "made in reliance upon" the advice of counsel. *Chevron* 974 F.2d at 1162 (9th Cir. 1992). In *Melendres*, the doctrine was "implicitly invoked" when witnesses testifying on behalf of defendant the Maricopa Sheriff's Office explained their alleged attempt to comply with a preliminary injunction by asserting that defendant's counsel had "reviewed" and were "looking into" compliance with the order. *Melendres*, 2015 WL 12911719, at *3 (D. Ariz. May 14, 2015). Further, the Court applied the doctrine *despite* the Sheriff's Office's *explicit*

[1] State Defendants' also noted that they had "gathered information and data from insurers and other entities regarding their experience providing transgender benefits, including reassignment surgery" but cited no specific documents, studies, or analyses.

disclaimer of any such defense in response to written discovery. *Melendres, et al. v. Penzone, et al.*, No. 2:07-cv-02513 (D. Ariz. Dec 12, 2007), Doc. 1045-3, Ex. N, at Resp.to Interrog. No. 9. There is no credible dispute, therefore, that State Defendants could have, and, in fact, have implicated the doctrine through their written discovery responses.

Third, State Defendants cite Ms. Isaacson's and Mr. Bender's current employment status to argue that neither has the authority to waive privilege. (Opp. 10-11) This argument is not only a red herring, but leads to absurd results. Both Ms. Isaacson and Mr. Bender were identified by the State Defendants as individuals possessing knowledge about the "reasons" for the Exclusion (Doc. 195-3, Ex .5 No. 2), which the State alleges are entirely non-discriminatory. (Doc. 89 at 28, J). State Defendants then proffered them as witnesses they would offer at trial (Doc. 146 ¶¶ 3, 5), and in response to Plaintiff's request to depose them, State Defendants chose to prepare them for and then defend them in those depositions. Ms. Isaacson therefore is far from a "non-party" witness, as State Defendants claim. (Opp. 12-14) Further, State Defendants point to Ms. Isaacson's status as a former employee to distract from the more foundational issue that during her deposition, they failed to timely object to her disclosure of the content of the legal advice State Defendants received regarding the legality of the Exclusion.[2] It would lead to absurd results if parties could avoid their duty to maintain the confidentiality of privileged information, and timely object to its disclosure, through the use of a "strategic spokesperson" lacking authority to waive privilege, as this Court has recognized. *Melendres*, 2015 WL 12911719, at *3 n.1 (rejecting argument that employee who testified on behalf of defendant was not authorized to waive the privilege because defendant had put forth and benefitted from employee's testimony, and holding

[2] State Defendants' cases on authority to waive privilege are all specific to the corporate context; they point to no authority or policy reason why this principle should be extended to public employees of the state, particularly when, as is the case here, the State maintains that its decisions were made for lawful reasons, and has a policy favoring the disclosure of governmental records. (Doc. 187 at 7)

that "[i]t would eviscerate the privilege and waiver doctrines if a party could immunize its voluntary disclosure in contravention of privilege simply by doing so through a strategic spokesperson.")

Fourth, State Defendants construct in Frankenstein fashion a wholly false and misleading "slippery slope" argument that Plaintiff somehow seeks to compel this Court to "hold that a waiver of privileged communications occurs whenever a party acknowledges that a lawyer was present at a meeting." (Opp. 8) State Defendants have waived attorney-client privilege through their own affirmative actions and attempting to leverage certain legal advice to their benefit, while simultaneously shielding that advice from Plaintiff's scrutiny. Plaintiff's argument is premised on these actions, not the mere fact that State Defendants received legal advice in connection with the Exclusion in 2016.[3] While Plaintiff is entitled to be skeptical of any allegations or claims made by the State Defendants, he only contends that he became entitled to examine privileged communications once State Defendants affirmatively set forth legal advice, and their understanding of that advice, as a rationale for the Exclusion in this litigation.

II. STATE DEFENDANTS WAIVED ATTORNEY-CLIENT PRIVILEGE BY DISCLOSING ADVICE OF COUNSEL

State Defendants fail to rebut their waiver of attorney-client privilege based on (1) disclosure to the Governor's Office from 2015 to 2018 and/or (2) disclosure during Ms. Isaacson's deposition without objection. (Mot. at 11-13)

A. Waiver By Sharing Legal Advice With Governor's Office

State Defendants have waived attorney-client privilege by sharing legal advice with the Governor's Office—an entity that State Defendants themselves have held out as a third party, distinct from ADOA. (Mot. 11-12) The Opposition contends that this

[3] Plaintiff rejects entirely State Defendants' cry wolf arguments that they are "damned if they do and damned if they don't" (Opp. 2), and these should be dismissed out of hand. Plaintiff does not seek to punish State Defendants for the fact of consulting counsel. He simply seeks to probe what State Defendants have put forward as an allegedly non-discriminatory basis for the Exclusion, which in fairness he must be allowed to do in order to effectively challenge the State's defense.

sharing between ADOA and the Governor's Office was protected by the common interest doctrine (Opp. 14-17), but no facts adduced thus far in the case support the doctrine's applicability here, including any of the largely irrelevant facts State Defendants recite concerning other disputes involving transgender issues.

The common interest doctrine applies in circumstances involving actual or prospective litigation. (Mot. 12) Where the doctrine has applied prior to the initiation of a lawsuit, the parties asserting it have generally been co-defendants cooperating with respect to a common indictment or dispute. State Defendants' own cases support this. *See Hunydee v. U.S.*, 355 F.2d 183, 185 (9th Cir. 1965) (applying common interest to where "two or more persons who are subject to possible indictment in connection with the same transactions[.]"); *U.S. v. Gonzalez*, 669 F.3d 974, 978-79 (9th Cir. 2012) (finding common interest between two potential codefendants); *U.S. v. Schwimmer*, 892 F.2d 237, 244 (2d Cir. 1989) (same). Nothing in the record supports that State Defendants and the Governor's Office coordinated their discussions of the Exclusion due to any pending or prospective dispute.[4] Rather, State Defendants and the Governor's Office, each distinct and separate governmental entities, worked together to make policy. The fact that these policy discussions may have been informed by changes in the law does not transform the policymaking purpose of their work together into a common interest purpose for imminent litigation. If it did, the common interest privilege would effectively apply to all policymaking work, so long as the conversation was in some way informed by law (as almost all policymaking is).

B. Waiver By Disclosing Legal Advice During Isaacson Deposition.

State Defendants attempt to rebut their waiver during Ms. Isaacson's deposition by wrongly arguing that Ms. Isaacson did "not reference legal advice." (Opp. 13). Ms. Isaacson clearly testified about the *content* of the legal advice given to State Defendants—*i.e.*, that State Defendants could exclude some, but not all transgender

[4] State Defendants failure to offer any supporting declaration corroborating that such coordination occurred or was intended is also telling.

benefits, and that they were not legally required to cover "gender reassignment surgery." (Mot. 6, 13)[5] State Defendants also reiterate that Ms. Isaacson could not, as a "non-party" and former employee, waive attorney-client privilege belonging to State Defendants. (Opp. 12-14). But Plaintiff does not contend that Ms. Isaacson waived the privilege via her testimony; rather, *State Defendants waived the privilege* by failing to assert it at the deposition and allowing Ms. Isaacson to testify about the content of privileged legal advice rendered to State Defendants. (Mot. 11)

III. THE MOTION STATES WHICH DOCUMENTS PLAINTIFF SEEKS

State Defendants argue, incorrectly, that the Motion does not sufficiently identify the documents it seeks. State Defendants' solitary support for this argument is entirely inapt. (Opp. 2 (citing *Hawkins v. Winkfield*, No. 2:19-cv-1228 TLN KJN P, 2021 WL 1193421, at *2 (E.D. Cal. Mar. 30, 2021) (holding that *pro se* motion was deficient due to failure to identify the "specific discovery request and responses he challenges"))) Here, Plaintiff has clearly identified the exact requests and responses that he challenges. (Doc 195-1). As State Defendants admit (Opp. 17), the Motion specifically identifies 85 documents Plaintiff alleges have been withheld improperly on the basis of attorney-client privilege. (Mot. 2) Because Plaintiff cannot currently review these documents, he can only assume that all 85 of them fall within the scope of what the Motion seeks *i.e.* communications related to "legal advice [State Defendants] received on the legality of the Exclusion." (Doc. 195-4)

Courts routinely decide motions of this nature by reference to "subject matter." *See Melendres* 2015 WL 12911719, at *6 (D. Ariz. May 14, 2015) (ordering production of privileged communications "on the subject matter" of the defendants' decision-making); *Chevron* 974 F.2d at 1163 (9th Cir. 1992) (remanding to district court to order production of privileged communications "relied upon . . . to support the reasonableness"

[5] Separate and apart from Ms. Isaacson's testimony, State Defendants' voluntarily disclosed the content of this legal advice in response to written discovery requests. (195-3, Ex. 5 at No. 1 (stating that the "State concluded, under the law, that it was not legally required to change its health plan[.]"))

of defendant's investment); *see also Hunt v. County of Orange*, 672 F.3d 606, 616 (9th Cir. 2012) (district courts have "broad discretion to manage discovery."). This is precisely what Plaintiff seeks here: production of all documents on the subject of the legality of the Exclusion *i.e.* the principal purported non-discriminatory basis for the State Defendants' maintenance of the Exclusion.

CONCLUSION

For all the reasons discussed above, Plaintiff's Motion should be granted.

Dated: June 10, 2021

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CERTIFICATE OF SERVICE

I hereby certify that on June 10, 2021, I electronically transmitted the attached document to the Clerk's office using the CM/ECF System for filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system.

/s/ Christine K. Wee
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ATTENTION ALL PARTIES AND COUNSEL
PLEASE REVIEW PARTIES AND COUNSEL LISTING

We have opened this appeal/petition based on the information provided to us by the appellant/petitioner and/or the lower court or agency. EVERY attorney and unrepresented litigant receiving this notice MUST immediately review the caption and service list for this case and notify the Court of any corrections.

Failure to ensure that all parties and counsel are accurately listed on our docket, and that counsel are registered and admitted, may result in your inability to participate in and/or receive notice of filings in this case, and may also result in the waiver of claims or defenses.

PARTY LISTING:
Notify the Clerk immediately if you (as an unrepresented litigant) or your client(s) are not properly and accurately listed or identified as a party to the appeal/petition. To report an inaccurate identification of a party (including company names, substitution of government officials appearing only in their official capacity, or spelling errors), or to request that a party who is listed only by their lower court role (such as plaintiff/defendant/movant) be listed as a party to the appeal/petition as an appellee or respondent so that the party can appear in this Court and submit filings, contact the Help Desk at http://www.ca9.uscourts.gov/cmecf/feedback/ or send a letter to the Clerk. If you or your client were identified as a party to the appeal/petition in the notice of appeal/petition for review or representation statement and you believe this is in error, file a motion to dismiss as to those parties.

COUNSEL LISTING:
In addition to reviewing the caption with respect to your client(s) as discussed above, all counsel receiving this notice must also review the electronic notice of docket activity or the service list for the case to ensure that the correct counsel are

listed for your clients. If appellate counsel are not on the service list, they must file a notice of appearance or substitution immediately or contact the Clerk's office.

NOTE that in criminal and habeas corpus appeals, trial counsel WILL remain as counsel of record on appeal until or unless they are relieved or replaced by Court order. *See* Ninth Circuit Rule 4-1.

REGISTRATION AND ADMISSION TO PRACTICE:
Every counsel listed on the docket must be admitted to practice before the Ninth Circuit AND registered for electronic filing in the Ninth Circuit in order to remain or appear on the docket as counsel of record. *See* Ninth Circuit Rules 25-5(a) and 46-1.2. These are two separate and independent requirements and doing one does not satisfy the other. If you are not registered and/or admitted, you MUST, within 7 days from receipt of this notice, register for electronic filing AND apply for admission, or be replaced by substitute counsel or otherwise withdraw from the case.

If you are not registered for electronic filing, you will not receive further notices of filings from the Court in this case, including important scheduling orders and orders requiring a response. Failure to respond to a Court order or otherwise meet an established deadline can result in the dismissal of the appeal/petition for failure to prosecute by the Clerk pursuant to Ninth Circuit Rule 42-1, or other action adverse to your client.

If you will be replaced by substitute counsel, new counsel should file a notice of appearance/substitution (no form or other attachment is required) and should note that they are replacing existing counsel. To withdraw without replacement, you must electronically file a notice or motion to withdraw as counsel from this appeal/petition and include your client's contact information.

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