



MEDICAL PLAN GENDER AFFIRMATION FAQ



WHAT DOES THE TRANSGENDER BENEFIT COVER?

The transgender benefit provides coverage for the treatment of gender dysphoria, formerly called gender identity disorder. Benefits are provided for medically necessary surgical services, including facility and anesthesia fees.

Benefits are available for:

- Specialized surgical procedures (breast/chest and genital)
- Body masculinization/feminization surgical procedures recognized as medically necessary

Requirements for surgical procedures vary and are outlined in this FAQ. This benefit works the same as other benefits in your medical plan. Standard copays, coinsurance, deductible, and limitations apply. There is no lifetime maximum for surgical transgender services.

Coverage for prescription drugs and mental health services you receive as you prepare for gender affirmation surgery are covered by your plan's prescription and mental health benefits.

WHO IS ELIGIBLE?

You are eligible to receive transgender services if you are enrolled in the Premera Medical Plan through F5.

Surgical gender affirmation services are considered medically necessary and are covered for employees, spouses/domestic partners, and dependents if:

- The covered individual is at least 18 years old, and
- The covered individual is diagnosed as having gender dysphoria or gender identity disorder

SPECIALIZED SURGICAL PROCEDURES

Covered services include, but are not limited to, the following surgeries. They must be medically necessary and meet plan requirements. A pre-service review is strongly recommended.

| Female to Male or Non-Binary | Male to Female or Non-Binary |
|---|--|
| Breast/Chest | |
| Mastectomy or breast reduction, Nipple reconstruction | Breast augmentation |
| Genital | |
| Scrotoplasty, Vulvectomy, Vaginectomy, Hysterectomy, Phalloplasty | Penectomy, Orchiectomy, Clitoroplasty, Labiaplasty, Vaginoplasty |

Additional surgical services are considered through pre-service review. These include, but are not limited to:

Covered

- Facial feminization/masculinization surgery
- Facial bone reduction or enhancement
- Blepharoplasty
- Subsequent breast augmentation
- Thyroid chondroplasty
- Laryngoplasty/shortening of vocal cords and therapy
- Rhinoplasty or nose implants
- Body contouring

Not Covered

- Skin resurfacing
- Padding or binding
- Waxing

DO I NEED APPROVAL TO RECEIVE SERVICES?

Your doctor is strongly encouraged to submit a pre-service review to Premera Blue Cross to find out if the plan covers your surgery. The pre-service review should be submitted by the physician who will perform the service(s) and can be submitted through the Premera Blue Cross Resources listed below.

For transgender services, the pre-service review should include:

- The surgical procedure(s) for which coverage is being requested
- Information that confirms that services are recognized as medically necessary per Premera's medical policy for the surgery being requested
- Required letter(s) of recommendation from mental health professionals

For genital surgery:

Genital surgery, breast/chest surgery and feminization/masculinization surgery, now all have the same requirements.

One letter from a mental health professional dated within 12 months that shows the member has been evaluated or treated within the last 12 months and the member meets all the requirements outlined in Premera's medical policy.

For breast/chest surgery:

- You must have one letter of recommendation for surgery from a mental health professional with the same information as noted for genital surgery.

For feminization/masculinization surgery:

- You must have one letter of recommendation for surgery from a mental health professional with the same information as noted for genital surgery.

Please note: Reviews may take up to 15 days to be completed.

CLAIMS PROCESSING AND REIMBURSEMENT:

You or your doctor will need to submit claims for processing.

If your doctor or facility is in-network:

Doctors or facilities (such as hospitals and surgical centers) who contract with Premera Blue Cross or another Blue Cross Blue Shield plan to provide services will submit claims for you.

If your doctor or facility is out-of-network:

You may submit a claim form to Premera Blue Cross. Please make sure you have all the procedure and diagnosis codes, as well as costs for each procedure, and medical records. This will ensure timely and accurate processing of your claim(s).

Many Gender Affirming Care doctors are out-of-network. If you receive services from an out-of-network doctor, your medical plan will pay at the out-of-network benefit level which can be subject to balance billing. Out-of-network doctors may require up-front payment for their services. Premera Blue Cross may be able to work with the doctor to reduce your costs. If interested, doctors may request a Letter of Agreement (LOA) by contacting any of the Premera Blue Cross resources below. Out-of-network doctors may submit a Letter of Agreement for review and potential approval when covered services are not available within the existing Premera Blue Cross network.

An authorization or approval can be done up to six months before a service is performed. Authorizations are valid for 12 months from the date of approval.

ADDITIONAL INFORMATION:

We're here to help! If you have questions about transgender services, claims, or the pre-service review process, call Premera Blue Cross Customer Service at 800.722.1471.

Use in-network doctors when possible to get the most out of your benefits. Find doctors in your network with the Find a Doctor tool when you log in at premera.com. Or call Customer Service at 800.722.1471. Remember—you have access to the entire Blue Cross Blue Shield network.

We advise you to keep copies of letters of recommendation and bring them to your doctor or surgeon. Your doctor will submit them as part of your pre-service review. Each recommendation must state that the surgery is medically necessary.

PREMERA BLUE CROSS RESOURCES

Customer Service:

800-722-1471 (6 a.m. - 6 p.m. PT)

Care Management:

800-722-1471 (6 a.m. - 6 p.m. PT)

Find a Doctor Tool: premera.com

Submit pre-service review requests to:

Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159
Fax: 800-866-4198

Submit claim forms to:

Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159
Fax: 425-918-5231