

Gender Dysphoria (Gender Identity Disorder) Treatment (for California Only)

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[Instructions for Use](#)

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Related Benefit Interpretation Policies
<ul style="list-style-type: none"> Family Planning: Infertility Services Medications and Off-Label Drugs
Related Medical Policies
<ul style="list-style-type: none"> Breast Reconstruction Breast Reduction Surgery

Application

This policy applies to:

- UnitedHealthcare West plans:
 - UnitedHealthcare of California (HMO)
 - UnitedHealthcare Benefits Plan of California (EPO/POS)
 - UnitedHealthcare Insurance Company (California)
- UnitedHealthcare Commercial fully-insured group plans

Federal/State Mandated Regulations

California Health and Safety Code (HSC) Article 5, Standards, Section 1367.042

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=1367.042.

- (a) A health care service plan shall notify enrollees and members of the public of all of the following information:
- The health plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.
 - The availability of the grievance procedure described in Section 1368, how to file a grievance, including the name of the plan representative and the telephone number, address, and email address of the plan representative who may be contacted about the grievance, and how to submit the grievance to the department for review after completing the grievance process or participating in the process for at least 30 days.
 - How to file a discrimination complaint with the United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.
- (b) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:
- In a conspicuously visible location in the evidence of coverage.
 - At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.
 - On the Internet Web site published and maintained by the health care service plan, in a manner that allows enrollees, prospective enrollees, and members of the public to easily locate the information.

- (c) (1) A specialized health care plan that is not a covered entity, as defined in Section 92.4 of Title 45 of the Code of Federal Regulations, subject to Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116) may request an exemption from the requirements under this section.
- (2) The department shall not grant an exemption under this subdivision to a specialized health care service plan that arranges for mental health benefits except for employee assistance program plans.
- (3) The department shall provide information on its Internet Web site about any exemptions granted under this subdivision.
- (d) This section does not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

[Amended by Stats. 2018, Ch. 92, Sec. 132. (SB 1289) Effective January 1, 2019.]

HSC Article 4, Solicitation and Enrollment, Section 1365.5

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=1365.5.

- (a) No health care service plan or specialized health care service plan shall refuse to enter into any contract or shall cancel or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise.
- (b) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise; except that premium, price, or charge differentials because of the age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited.
- (c) It shall be deemed a violation of subdivision (a) for any health care service plan to utilize marital status, living arrangements, occupation, sex, beneficiary designation, ZIP Codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Nothing in this section shall be construed to alter in any manner the existing law prohibiting health care service plans from conducting tests for the presence of human immunodeficiency virus or evidence thereof.
- (d) This section shall not be construed to limit the authority of the director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.
- (e) "Sex" as used in this section shall have the same meaning as "gender," as defined in Section 422.56 of the Penal Code.
- (f) The changes made to this section by the act adding this subdivision shall only apply to contracts issued, amended, or renewed on or after January 1, 2011.

HSC Section 1374.72, Health Plan to Cover Mental Health and Substance Use Disorder

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.72.&lawCode=HSC

- (a) (1) Every health care service plan contract *[and every disability insurance policy]* issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions as specified in subdivision (c).
- (2) For purposes of this section, "mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.
- (3) (A) For purposes of this section, "medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
 - (i) In accordance with the generally accepted standards of mental health and substance use disorder care.
 - (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

- (iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.
- (B) This paragraph does not limit in any way the independent medical review rights of an enrollee or subscriber under this chapter.
- (4) For purposes of this section, “health care provider” means any of the following:
 - (A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
 - (B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
 - (C) A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
 - (D) An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
 - (E) An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
 - (F) A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
 - (G) A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
 - (H) A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.
- (5) For purposes of this section, “generally accepted standards of mental health and substance use disorder care” has the same meaning as defined in paragraph (1) of subdivision (f) of Section 1374.721.
- (6) A health care service plan shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.
- (7) All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 1374.721 [Section 10144.52]. This paragraph does not deprive an enrollee of the other protections of this chapter, including but not limited to grievances, appeals, independent medical review, discharge, transfer, and continuity of care.
- (8) A health care service plan that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including but not limited to the plan’s subsequent rescission, cancellation, or modification of the enrollee’s or subscriber’s contract, or the plan’s subsequent determination that it did not make an accurate determination of the enrollee’s or subscriber’s eligibility. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan.
- (b) The benefits that shall be covered pursuant to this section shall include but not be limited to the following:
 - (1) Basic health care services, as defined in subdivision (b) of Section 1345.
 - (2) Intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment.
 - (3) Prescription drugs, if the plan contract includes coverage for prescription drugs.
- (c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include but not be limited to all of the following patient financial responsibilities:
 - (1) Maximum annual and lifetime benefits, if not prohibited by applicable law.
 - (2) Copayments and coinsurance.
 - (3) Individual and family deductibles.
 - (4) Out-of-pocket maximums.
- (d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to “arrange coverage to ensure the delivery of medically necessary out-of-network services” includes but is not limited to providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.
- (e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.
- (f) (1) For the purpose of compliance with this section, a health care service plan may provide coverage for all or part of the mental health and substance use disorder services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

- (2) A health care service plan shall provide the mental health and substance use disorder coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans, provided that all appropriate mental health or substance use disorder services are actually available within those geographic service areas within timeliness standards.
- (3) Notwithstanding any other law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing, provided that these practices are consistent with Section 1374.76 [Section 10144.4] of this code, and Section 2052 of the Business and Professions Code.
- (g) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter.
- (h) A health care service plan shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including but not limited to special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.
- (i) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

HSC Section 1374.721, Medical Necessity Determination; Utilization Review Criteria

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.721.&lawCode=HSC

- (a) A health care service plan [disability insurer] that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.
- (b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.
- (c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:
 - (1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).
 - (2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).
- (d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).
- (e) To ensure the proper use of the criteria described in subdivision (b), every health care service plan shall do all of the following:
 - (1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.
 - (2) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.
 - (3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees.
 - (4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.
 - (5) Conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

- (6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.
- (7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.
- (f) The following definitions apply for purposes of this section:
 - (1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
 - (2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1374.72.
 - (3) "Utilization review" means either of the following:
 - (A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.
 - (B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.
 - (4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health care service plan to conduct utilization review.
- (g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a health care service plan contract, including prescription drugs.
- (h) This section applies to a health care service plan that conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on behalf of a health care service plan.
- (i) The director may assess administrative penalties for violations of this section as provided for in Section 1368.04, in addition to any other remedies permitted by law.
- (j) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.
- (k) This section does not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

California Code of Regulations Title 10, Section 2561.2

[https://govt.westlaw.com/calregs/Document/ID8C6D39D5C2F11EC9C68000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/ID8C6D39D5C2F11EC9C68000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

- (a) An admitted insurer shall not, in connection with health insurance as defined in subdivision (b) of Insurance Code section 106, discriminate on the basis of an insured's or prospective insured's actual or perceived gender identity, or on the basis that the insured or prospective insured is a transgender person. The discrimination prohibited by this Section 2561.2 includes any of the following:
 - (1) Denying, cancelling, limiting or refusing to issue or renew an insurance policy on the basis of an insured's or prospective insured's actual or perceived gender identity, or for the reason that the insured or prospective insured is a transgender person;
 - (2) Demanding or requiring a payment or premium that is based in whole or in part on an insured's or prospective insured's actual or perceived gender identity, or for the reason that the insured or prospective insured is a transgender person;
 - (3) Designating an insured's or prospective insured's actual or perceived gender identity, or the fact that an insured or prospective insured is a transgender person, as a preexisting condition for which coverage will be denied or limited; or
 - (4) Denying or limiting coverage, or denying a claim, for services including but not limited to the following, due to an insured's actual or perceived gender identity or for the reason that the insured is a transgender person:

- (A) Health care services related to gender transition if coverage is available for those services under the policy when the services are not related to gender transition, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training; or
 - (B) Any health care services that are ordinarily or exclusively available to individuals of one sex when the denial or limitation is due only to the fact that the insured is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, gender transition.
- (b) This Section 2561.2 shall have no bearing on the question of whether or not a particular health care service is medically necessary in any individual case.

State Market Plan Enhancements

None

Covered Benefits

Important Notes:

- Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.
- The California Department of Managed Health Care requires that health care service plans apply the most recent criteria and guidelines developed by the World Professional Association for Transgender Health (WPATH) when conducting utilization review of treatment for gender dysphoria. Accordingly, coverage for medically necessary treatment of gender dysphoria is based on the most recent version of WPATH Standards of Care for the Health of Transgender and Gender Diverse People.
- Prior authorization of medically necessary services must be done by UnitedHealthcare or delegated providers as determined by UnitedHealthcare.

Criteria for Adults

Hormonal treatment for gender dysphoria may be indicated when the following criteria are met, as documented in an assessment from a health care professional who has competencies in the assessment of transgender people:

- Gender incongruence is marked and sustained;
- Meets diagnostic criteria for gender incongruence;
- Demonstrates capacity to consent for the specific gender-affirming hormone treatment;
- Other possible causes of apparent gender incongruence have been identified and excluded;
- Mental health and physical conditions that could negatively impact the outcome of treatment have been assessed, with risks and benefits discussed; and
- Understands the effect of gender-affirming hormone treatment on reproduction and they have explored reproductive options.

Surgical treatment for gender dysphoria may be indicated when the following criteria are met, as documented in an assessment from a health care professional who has competencies in the assessment of transgender people:

- Gender incongruence is marked and sustained;
- Meets diagnostic criteria for gender incongruence;
- Demonstrates capacity to consent for the specific gender-affirming surgical intervention;
- Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options;
- Other possible causes of apparent gender incongruence have been identified and excluded;
- Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed; and
- Stable on their gender affirming hormonal treatment regimen, if indicated based on the procedure planned (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

Hormone and/or surgical treatment for individuals seeking to detransition or retransition may be indicated when, in addition to the applicable criteria above, the following criteria are met:

- Documentation of a comprehensive multidisciplinary assessment by health care professionals experienced in transgender health. The assessment must be inclusive of, but not limited to, the following:

- Exploration of concerns with previous physical changes and efforts to ensure similar concerns are not replicated by further physical changes.
- A recommended period of living in role before further physical changes are recommended.
- Evaluation of the etiology of regret, if applicable, as well as the temporal stability of the surgical request.

Criteria for Adolescents

Puberty blocking agents for gender dysphoria may be indicated when the following criteria are met, as documented in an assessment from a member of a multidisciplinary team, including both medical and mental health professionals, reflecting the assessment and opinion from the team:

- Gender diversity/incongruence is marked and sustained over time;
- Meets the diagnostic criteria of gender incongruence;
- Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally;
- Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility; and
- Reached Tanner stage 2.

Hormonal treatment for gender dysphoria may be indicated when the following criteria are met, as documented in an assessment from a member of a multidisciplinary team, including both medical and mental health professionals, reflecting the assessment and opinion from the team:

- Gender diversity/incongruence is marked and sustained over time;
- Meets the diagnostic criteria of gender incongruence;
- Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally;
- Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility; and
- Reached Tanner stage 2.

Surgical treatment for gender dysphoria may be indicated when the following criteria are met, as documented in an assessment from a member of a multidisciplinary team, including both medical and mental health professionals, reflecting the assessment and opinion from the team:

- Gender diversity/incongruence is marked and sustained over time;
- Meets the diagnostic criteria of gender incongruence;
- Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally;
- Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility; and
- At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

When the applicable criteria above are met for adults/adolescents:

- Hormone treatments listed in WPATH, Version 8, Appendix C are covered.
- Surgical procedures listed in WPATH, Version 8, Appendix E are covered.
- Puberty blocking agents that are clinically indicated per WPATH are covered.

Not Covered

The following are not covered:

- Surgical treatment not prior authorized by UnitedHealthcare or by the member's network medical group
- Drugs for hair loss

- Drugs for sexual performance for members that have undergone genital reconstruction
- Drugs or devices not approved by the FDA for use in the United States
- Treatment received outside of the United States
- Drugs when prescribed for cosmetic purposes
- Surrogate parenting, donor eggs, donor sperm and host uterus (refer to member EOC)
- Transportation, meals, lodging or similar expenses except as may be otherwise covered in the member's EOC

References

DMHC All Plan Letter: Health and Safety Code Section 1365.5 Compliance
[https://www.dmhc.ca.gov/Portals/0/Docs/OPL/Health%20and%20Safety%20Code%20Section%201365%205%20Compliance%20\(2%205%202015\)%201.pdf?ver=2021-05-06-095344-000](https://www.dmhc.ca.gov/Portals/0/Docs/OPL/Health%20and%20Safety%20Code%20Section%201365%205%20Compliance%20(2%205%202015)%201.pdf?ver=2021-05-06-095344-000).

DMHC All Plan Letter (APL 21-002 – Implementation of SB 855, MH/SUD Coverage
[https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2021-002%20-%20Implementation%20of%20SB%20855,%20%20MHSUD%20Coverage%20\(1%205%202021\).pdf](https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2021-002%20-%20Implementation%20of%20SB%20855,%20%20MHSUD%20Coverage%20(1%205%202021).pdf).

DMHC Director's Letter 12K "Gender Non-Discrimination Requirements"
<https://www.dmhc.ca.gov/Portals/0/LawsAndRegulations/DirectorsLettersAndOpinions/dl12k.pdf>.

World Professional Association for Transgender Health (WPATH). Standards of care for the health of transgender and gender diverse people. 8th edition. 2022. Available at: <https://www.wpath.org>. Accessed December 2, 2024.

Policy History/Revision Information

Date	Summary of Changes
01/01/2025	<p>Template Update</p> <ul style="list-style-type: none"> • Modified font style • Updated reference links to related Medical Policies (previously classified as Medical Management Guidelines) <p>Supporting Information</p> <ul style="list-style-type: none"> • Updated <i>References</i> section to reflect the most current information • Archived previous policy version BIP185.S

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.