United Healthcare

UnitedHealthcare West

Benefit Interpretation Policy Update Bulletin: February 2026

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Benefit Interpretation Policy Updates

Updated

Policy Title	Effective Date	Applicable State(s)	Summary of Changes
Foot Care and Podiatry Services	Feb. 1, 2026	California	**Covered Benefits** ***Routine Foot Care*** • Replaced reference to "peripheral vascular *conditions*" with "peripheral vascular *diseases*" • Added language to clarify routine foot care of mycotic nails, in the absence of a systemic condition, may be covered when a non-ambulatory member suffers from pain *and/*or secondary infection resulting from the thickening and dystrophy of the infected toenail plate
Skilled Nursing Facility (SNF): Skilled Nursing Facility (SNF) Care	Feb. 1, 2026	California	**State Market Plan Enhancements** • Added language to clarify a benefit period begins on the date the member is admitted to a hospital or skilled nursing facility at a skilled level of care; a prior three-day stay in an acute care hospital is not required *to begin a benefit period*

Revised

Policy Title	Effective Date	Applicable State(s)	Summary of Changes
Gender Dysphoria (Gender Identity Disorder) Treatment	Apr. 1, 2026	Washington	**Related Policies** • Added reference link to the Medical Benefit Drug Policy titled *Gonadotropin Releasing Hormone Analogs* • Removed reference link to the Benefit Interpretation Policy titled *Medications and Off-Label Drugs* **Application** • Removed language indicating this policy applies to UnitedHealthcare West plans (UnitedHealthcare of Washington, Inc.) **Federal/State Mandated Regulations** • Removed language pertaining to the *Revised Code of Washington (RCW) Section 74.09.675* **State Market Plan Enhancements** • Removed reference link to the *Washington Office of the Insurance Commissioner, Commissioner's Letter Gender Identity Non Discrimination Requirements* • Removed language pertaining to *Washington Administrative Code Section 284.43.5622* **Covered Benefits** • Revised language to indicate: ○ 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

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Gender Dysphoria (Gender Identity Disorder) Treatment (continued)	Apr. 1, 2026	Washington (continued)	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 ▪ Understands the effect of gender-affirming hormone treatment on reproduction and they have explored reproductive options ○ Surgical treatment for Gender Dysphoria may be indicated for individuals who provide documentation that the 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 ▪ Favorable psychosocial-behavioral evaluation including screening and identification of risk factors or potential postoperative challenges ▪ For breast surgery (mastectomy, breast reduction, or breast augmentation), in addition to the above criteria, a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets the following criteria: – For breast augmentation, continued Gender Dysphoria following the completion of 12 months of continuous hormone therapy prior to the breast procedure is required ▪ For thyroid cartilage reduction and/or voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords), in addition to the above criteria, a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets all of the following criteria: – Completion of 6 months of continuous hormone therapy prior to surgery is required for voice masculinization – For voice modification surgery, documentation of presurgical voice lessons and/or therapy ▪ For genital surgery, in addition to the above criteria, a written clinical assessment from at least two Qualified Healthcare Professional experienced in treating Gender

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Gender Dysphoria (Gender Identity Disorder) Treatment (continued)	Apr. 1, 2026	Washington (continued)	Dysphoria, who have independently assessed the individual, is required; the assessment must document that an individual meets all of the following criteria: – Complete at least 12 months of successful continuous full-time real-life involvement in the identified gender – Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated or not indicated for gender) – Treatment plan that includes ongoing follow-up and care by a Qualified Healthcare Professional experienced in treating Gender Dysphoria ○ Gender affirming surgery is considered an irreversible intervention; although infrequent, reversal of prior gender affirming surgery may be covered when the medical necessity criteria for the requested treatment above are met ○ Surgical treatment for Gender Dysphoria may be indicated for individuals who provide documentation that the 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 ▪ Favorable psychosocial-behavioral evaluation including screening and identification of risk factors or potential postoperative challenges ▪ For breast surgery (mastectomy, breast reduction, or breast augmentation), in addition to the above criteria, a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets the following criteria: – For breast augmentation, continued Gender Dysphoria following the completion of 12 months of continuous hormone therapy prior to the breast procedure is required ▪ For thyroid cartilage reduction and/or voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords), in addition to the above criteria, a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets all of the following criteria: – Completion of 6 months of continuous hormone therapy prior to surgery is required for voice masculinization – For voice modification surgery, documentation of presurgical voice lessons and/or therapy ▪ For genital surgery, in addition to the above criteria, a written clinical assessment

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Gender Dysphoria (Gender Identity Disorder) Treatment (continued)	Apr. 1, 2026	Washington (continued)	from at least two Qualified Healthcare Professional experienced in treating Gender Dysphoria, who have independently assessed the individual, is required; the assessment must document that an individual meets all of the following criteria: – Complete at least 12 months of successful continuous full-time real-life involvement in the identified gender – Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated or not indicated for gender) – Treatment plan that includes ongoing follow-up and care by a Qualified Healthcare Professional experienced in treating Gender Dysphoria ***Criteria for Adolescents*** ○ In addition to the above criteria, for surgical treatment for gender dysphoria in adolescents (individuals under the age of 18), a comprehensive biopsychosocial 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 ▪ 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 ○ Gender affirming surgery is considered an irreversible intervention; although infrequent, reversal of prior gender affirming surgery may be covered when the medical necessity criteria for the requested treatment above are met ***Adults and Adolescents*** ○ When the above criteria are met, the following surgical procedures and/or therapies to treat Gender Dysphoria are medically necessary and covered as a benefit for both adults and adolescents: ▪ Bilateral mastectomy or breast reduction

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Gender Dysphoria (Gender Identity Disorder) Treatment (continued)	Apr. 1, 2026	Washington (continued)	▪ Breast augmentation with breast implants or fat transfer ▪ Clitoroplasty (creation of clitoris) ▪ Hysterectomy (removal of uterus) ▪ Labiaplasty (creation of labia) ▪ Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria ▪ Metoidioplasty (creation of penis, using clitoris) ▪ Orchiectomy (removal of testicles) ▪ Penectomy (removal of penis) ▪ Penile prosthesis ▪ Phalloplasty (creation of penis) ▪ Salpingo-oophorectomy (removal of fallopian tubes and ovaries) ▪ Scrotoplasty (creation of scrotum) ▪ Testicular prostheses ▪ Thyroid cartilage reduction/reduction thyroid chondroplasty/tracheal shave (removal or reduction of the Adam's apple) ▪ Urethroplasty (reconstruction of female urethra) ▪ Urethroplasty (reconstruction of male urethra) ▪ Vaginectomy (removal of vagina) ▪ Vaginoplasty (creation of vagina) ▪ Voice lessons and/or voice therapy (with or without surgery) ▪ Voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords) ▪ Vulvectomy (removal of vulva) **Not Covered** • Revised list of non-covered services; removed: ○ Surgical or cross-gender hormone treatment for members under 18 years of age; hormone therapy for members under 18 years of age is reviewed on a case-by-case basis by UnitedHealthcare ○ Surgical treatment not prior authorized by UnitedHealthcare or the delegated participating medical group/IPA ○ 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 (drugs or devices approved by the FDA will be considered for off-label use according to the Benefit Interpretation Policy titled *Medications and Off-Label Drugs*) ○ GnRH/Gonadotropin-Releasing Hormone Agonist (i.e., Lupron Depot, Vantas/Histrelin)

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Gender Dysphoria (Gender Identity Disorder) Treatment (continued)	Apr. 1, 2026	Washington (continued)	drugs for use in puberty suppression are considered to be off-label ○ Drugs when prescribed for cosmetic purposes ○ Coverage does not apply to members that do not meet the criteria listed in the eligibility qualifications for surgery [in the *Covered Benefits* section of the policy] ○ Surrogate parenting, donor eggs, donor sperm, and host uterus [refer to member's Evidence of Coverage (EOC)] ○ Transportation, meals, lodging or similar expenses unless medically necessary treatment outside the state of Washington is authorized and directed by plan's medical director ▪ Travel expense reimbursement is limited to reasonable expenses for transportation, meals, and lodging for the member to obtain authorized surgical consultation, surgical procedure(s), and follow-up care, when the authorized surgeon and facility are located outside the state of Washington ▪ The transportation and lodging arrangements must be arranged by or approved in advance by UnitedHealthcare ▪ Reimbursement excludes coverage for alcohol and tobacco ▪ Food and lodging expenses are not covered for any day a member is not receiving authorized surgical services • Removed notation indicating the drug related exclusions listed [in the *Not Covered* section of the policy] apply to drugs administered by provider in a medical setting (including but not limited to office, outpatient, or inpatient facility); for drugs obtained at a pharmacy, check with the pharmacy plan administrator for information on covered and excluded drugs **Definitions** • Added definition of: ○ Gender Dysphoria in Adolescents and Adults ○ Gender Dysphoria in Children ○ Qualified Healthcare Professional • Removed definition of "Gender Identity Disorder/Gender Dysphoria" **Supporting Information** • Updated *References* section to reflect the most current information

General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced, or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Management Guideline Update Bulletin was developed to share important information regarding changes to our Medical Policies and Medical Benefit Drug Policies. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

A new policy detailing applicable federal/state mandated regulations, state market plan enhancements, and/or benefit coverage guidelines has been adopted for a health service (e.g., test, drug, device, or procedure)

Updated

An existing policy has been reviewed and no changes have been made to the applicable federal/state mandated regulations, state market plan enhancements, and/or benefit coverage guidelines; however, supporting information such as definitions and reference links may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the applicable federal/state mandated regulations, state market plan enhancements, and/or benefit coverage guidelines

Replaced

An existing policy has been replaced with a new or different policy

Retired

An existing policy has been retired due to lack of federal/state mandated regulations, state market plan enhancements, and/or benefit plan changes

The complete library of UnitedHealthcare Benefit Interpretation Policies is available at **UHCprovider.com/policies** > For Commercial Plans > UnitedHealthcare West Benefit Interpretation Policies.