Covered benefits are listed in three (3) Sections - A, B and C. 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.

**Essential Health Benefits for Individual and Small Group**
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of...
Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage.

A. FEDERAL/STATE MANDATED REGULATIONS

1. Women’s Health and Cancer Rights Act of 1998, § 713 (a): "In general, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications, all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient."

   a. Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, renewed, or delivered in this state on or after July 1,1999, shall cover reconstructive surgery, as defined in subdivision (c) that is necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c). Nothing in this section shall be construed to require coverage for cosmetic surgery, as defined in subdivision (d).
   b. No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual competent to evaluate the specific clinical issues involved in the care requested.
   c. "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
      1) To improve function
      2) To create a normal appearance to the extent possible
   As of July 1, 2010, "reconstructive surgery" shall include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery, as defined in paragraph (c), for cleft palate procedures.
   For purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
   d. "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
   e. In interpreting the definition of reconstructive surgery, a health care service plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:
      1) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the member.
      2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in
reconstructive surgery, offer only a minimal improvement in the appearance of the member.

3) Denial of payment for procedures performed without prior authorization.

4) For services provided under the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), denial of the proposed surgery if the procedure offers only a minimal improvement in the appearance of the member, as may be defined in any regulations that may be promulgated by the State Department of Health Care Services.

5) As applied to services described in paragraph (2) of subdivision (c) only, this section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code, where such contracts do not provide coverage for California Children’s Services (CCS) or dental services.

B. STATE MARKET PLAN ENHANCEMENTS

1. Members may have benefits for Transgender Reassignment Surgery (a sex change). Refer to the Gender Dysphoria (Gender Identity Disorder) Treatment BIP.

2. Medically necessary reduction mammoplasty is a covered benefit when medical criteria are met and approved and authorized by the participating PMG/IPA or UnitedHealthcare Medical Director. Reviews are based on both of the following:
   b. Photographs

C. COVERED BENEFITS

**IMPORTANT NOTE:** Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

**Note:** Reconstructive procedures require preauthorization by the Member’s Primary Care Physician, Medical Group or UnitedHealthcare in accordance with the standards of care practiced by Physicians specializing in reconstruction surgery who are competent to evaluate the specific clinical issues involved in the care requested.

1. Reconstructive Surgery when needed to correct or repair abnormal structures of the body caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors or disease to improve function or create a normal appearance to the extent possible. Also review sections A and B above.
   a. In determining coverage for Reconstructive Procedures that are not intended to improve function, but which are designed only “To create a normal appearance to the extent possible”, relevant factors to consider include:
      1) Patient’s prior appearance
      2) Ethnicity
      3) Body habitus (general appearance)
      4) Age (changes consistent with aging are considered normal)
      5) Bilaterality (comparison to the contralateral side)
      6) The degree of deviation from the generally-accepted range of normal, taking into consideration reasonable expectations of surgical outcome, based upon professional medical judgement and physician review of clinical photographs, where appropriate
   b. Examples include, but are not limited to:
      1) Release of scar contracture
      2) Breast reduction surgery (mammoplasty) based on medical necessity. See Section B. See Medical Management Guideline: Breast Reduction Surgery.
      3) Treatment of Gynecomastia. See Medical Management Guideline: Gynecomastia Treatment.
      4) Surgery to correct hypospadias
c. Examples of covered Reconstructive Surgeries or treatments that would be performed to correct abnormal conditions caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors or disease include, but are not limited to:
   1) Release of scar contracture
   2) Surgical correction of microtia (ear absence or deformity)
   3) Breast reconstruction due to congenital absence of a breast. See Medical Management Guideline: Breast Reconstruction Post Mastectomy
   4) Breast reconstruction to correct breast asymmetry. See Medical Management Guideline: Breast Reconstruction Post Mastectomy and Breast Repair/Reconstruction Not Following Mastectomy
   5) Surgical treatment of polydactyl (extra fingers, toes)
   6) Surgical correction of gynecomastia; See Medical Management Guideline: Gynecomastia Treatment
   7) Surgical correction of hypospadias
   8) Reconstruction of the jaw after the removal of tumor or cancer. See Medical Management Guideline: Orthognathic (Jaw) Surgery
   9) Repair of cleft palate and cleft lip See Medical Management Guideline: Orthognathic (Jaw) Surgery
   10) Multi-stage Reconstructive Procedures that are part of an authorized treatment plan e.g. removal of a large hemangioma, removal of port wine stain, breast reconstruction, scar revisions
   11) Blepharoplasty for:
       a. Traumatic eye injury (e.g., orbital roof fracture) or
       b. Neurological ptosis (e.g. myasthenia gravis, third nerve paresis, and Horner syndrome (unilateral pupillary abnormality with ptosis caused by sympathetic nerve damage)) or
       c. Ectropion (outward turning of the upper or lower eyelid) or
       d. Entropion (inward turning of upper or lower eyelid)
       e. Brow lift. See Medical Management Guideline Blepharoplasty, Blepharoptosis and Brow Ptosis Repair

2. Reconstructive Surgery requests may be approved if the surgery either meets the criteria for coverage under Section A or meets the criteria for medical necessity. If above criteria are not met, a surgical procedure may still be covered when medical necessity criteria for the surgery are met.

Examples of conditions and procedures that may be covered when medical necessity criteria are met:
See Medical Necessity Benefit Interpretation Policy
b. Panniculectomy See Medical Management Guideline: Panniculectomy and Body Contouring Procedures
c. Repair of ptosis (drooping of the eyelids). See Medical Management Guideline: Blepharoplasty, Blepharoptosis and Brow Ptosis Repair
d. Blepharoplasty See Medical Management Guideline: Blepharoplasty, Blepharoptosis and Brow Ptosis Repair

D. NOT COVERED

1. Reconstructive Surgeries are not covered when there is another more appropriate surgical procedure that has been offered to the member as determined or defined by UnitedHealthcare or designee or when only minimal improvement in the member’s appearance is expected to be achieved.

2. Non-medically necessary Cosmetic, Elective or voluntary Enhancement Procedures or Services, supplies and medications.
Examples include, but are not limited to:
   a. Surgical Procedures to correct consequences of normal aging
   b. Surgical Procedures to remove common, benign skin lesions NOT caused by Congenital Defects, developmental abnormalities, trauma, infection, tumors, or disease
c. Services related to hereditary pattern baldness, sexual performance, athletic performance, Cosmetic purposes, anti-aging, and mental performance
d. Tattoo removal, dermabrasion or liposuction

E. DEFINITIONS

2. Cosmetic Services and Surgery: Cosmetic Surgery and Cosmetic Services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance.
3. Reconstructive Surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible.
4. Elective Enhancements: Technologies, drugs, devices, items and supplies for Elective, improvements, alterations, or Enhancements of appearance, skills, performance capability, physical attributes, are not covered. This exclusion includes, but is not limited to, Elective improvements, alterations, Enhancements, augmentation, or genetic manipulation related to aging, athletic performance, intelligence, weight or Cosmetic appearance.

F. POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
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<tbody>
<tr>
<td>10/01/2018</td>
<td>Updated policy header to reflect the most current UnitedHealthcare West branding; modified list of applicable products to encompass new benefit plans effective Jan. 1, 2019</td>
</tr>
</tbody>
</table>
| 01/01/2018 | Definitions
          | • Modified definition of “Reconstructive Surgery”                                  |
          | • Archived previous policy version BIP169.F                                       |