Gender Dysphoria (Gender Identity Disorder) Treatment

Policy Number: BIP198.H
Effective Date: December 1, 2021

Instructions for Use

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Related Benefit Interpretation Policy

- Medications and Off-Label Drugs

Related Medical Management Guidelines

- Blepharoplasty, Blepharoptosis and Brow Ptosis Repair
- Breast Reconstruction Post Mastectomy and Poland Syndrome
- Breast Reduction Surgery
- Breast Repair/ Reconstruction Not Following Mastectomy
- Gender Dysphoria Treatment Excluding California
- Rhinoplasty and Other Nasal Surgeries

Federal/State Mandated Regulations

Oregon Division of Financial Regulation Bulletin DFR 2016-1 Gender Identity Issues in the Transaction and Regulation of Insurance in Oregon.
http://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2016-01.pdf

State Market Plan Enhancements

None

Covered Benefits

Important Note: 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.

Refer to the member's EOC/SOB or contact the Customer Service Department to determine coverage eligibility.

Refer to the Medical Management Guideline titled Gender Dysphoria Treatment Excluding California and Washington

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

Coverage is available for medical, behavioral or pharmacological treatment that is Medically Necessary for Gender Dysphoria. UnitedHealthcare does not exclude or deny Covered Health Care Benefits based on an associated diagnosis of Gender Dysphoria, or otherwise discriminate against the Member on the basis that treatment is for Gender Dysphoria. For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

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Not Covered

None

Policy History/Revision Information

Date	Summary of Changes
05/01/2022	**Covered Benefits** • Updated reference link to reflect title change for the Medical Management Guideline titled *Gender Dysphoria Treatment Excluding California and Washington* (previously titled *Gender Dysphoria Treatment Excluding California*)
12/01/2021	• Routine review; no change to benefit coverage guidelines • Archived previous policy version BIP198.G

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.

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