ADVOCATES FOR TRANS EQUALITY

Trans Health Project

Working for Transgender Equal Rights

Health Insurance - Understanding Your Plan

To understand what your health plan covers and what legal rights and remedies are going to apply to your situation, you will need to complete these steps:

- Get a copy of your insurance plan booklet
- Look for an explicit exclusion
- Determine whether your plan is self-funded or insured
- Get your insurance company's clinical criteria

Learn more about each step by expanding the buttons below.

If you need insurance, see Choosing a Plan. Once you understand your plan, you can move to the next section, Applying for Coverage.

How to Get Your Insurance Plan Booklet

It's not enough to have your insurance company's general clinical policy on gender dysphoria treatments. Those only tell you how the insurance company evaluates claims *in general*, not whether or not your plan excludes some or all trans care.

Get a copy of *your* insurance policy

The document you need can have a variety of names such as:

- Certificate of Coverage
- Summary Plan Description
- Member Handbook
- Benefits Certificate
- Certificate of Insurance

It's a big 70+ page document that lists all of the exclusions and limitations. You can usually get a PDF version, but you may have been issued an actual paper booklet. If you received a paper booklet when you started on the plan, make sure you have the most up-to-date plan document as it is typically revised each year.

If you have a benefits or insurance website, login and begin your search there. You may see a lot of other documents there that are not your plan booklet.

Things that are not your plan booklet

- Any document that doesn't have an exclusions and limitations section.
- A colorful PDF full of pictures telling you about all of the different benefits your company offers.
- The "Summary of Benefits and Coverage," which is a chart that lists things such as deductibles and copays for various types of health care. That document is useful for understanding what you will have to pay out-of-pocket.

- A document that says the exclusions can be found elsewhere. If you cannot find an exclusion or limitation section, it is definitely not your plan booklet.

If you weren't able to find it online

If it's an individual insurance plan, you can call the number on the back of your card and ask them to send it to you. Make sure you explain to them that you want the big document that lists all of the exclusions, not just the summary of benefits chart.

If you have a plan through your employer or your parent's or partner's employer, you can contact HR or the benefits department. It's best to do this by email, and you should ask for what's called the "Summary Plan Description." By law, most employers are required to provide this document to you if you request it in writing.

Look for an Explicit Exclusion

If you already have your plan booklet, go to the exclusions and limitations section and see if they have an explicit exclusion for transgender-related health care. It might say something such as "transsexual surgery," "sex transformations," "gender reassignment surgery," or "sex change." If you have a PDF you can search for the words "sex" or "gender" and that will usually bring it up.

Occasionally you might be lucky and find that there is explicit coverage listed for trans-related care. Sometimes only certain kinds of trans-related care are covered and others excluded.

If there is an explicit exclusion, that does not necessarily mean you cannot get coverage.

There are several reasons why the exclusion might not be valid:

- The plan booklet might simply be out of date. Insurance companies and employers don't always keep their plans up to date. There may be a separate shorter document that lists "material modifications" to the plan document. Many plans removed their exclusions in January of 2017 in response to nondiscrimination regulations issued under the Affordable Care Act (Obamacare).
- The insurance plan might be regulated by one of the many states whose insurance departments have issued guidelines or regulations saying that there cannot be categorical exclusions for all trans-related care. Note that if this is an employer-based plan, the state where the insurance plan was issued might be different from the state where you live, and it's the state where the plan was issued that governs, not the state where you live.
- Even if insurance protections don't apply to your plan, exclusions have been found by courts to be unlawful under employment non-discrimination laws.

Differences Between Self-funded and Insured Plans

If you have health care coverage through an employer (or some universities' student health plans), it's going to be one of two things: an insurance plan or a self-funded health plan. An insurance plan is where the employer buys a group insurance plan from an insurance company. The insurance company is responsible for paying all of the claims and administering the plan. In a self-funded plan, the employer sets aside a big pool of money to which employees and employers contribute and that money is used to pay out the claims. The confusing part is that the employer generally hires an insurance company such as Anthem or UnitedHealthcare to administer the plan and that's the name that appears on your insurance card.

In a self-funded plan, the employer is ultimately responsible for the terms of the plan. The way this works in practice, however, is that insurance companies offer set plans to employers, and generally, that's the source of these explicit trans exclusions. Many employers never sat down and decided to exclude trans health care. But the fact that your employer is responsible for the exclusion means you can ask them to remove it.

I thought my state prohibited trans insurance discrimination

You may wonder how it can be the case that you can live in a state such as New York that has an insurance bulletin prohibiting exclusions and work for a New York-based employer, and yet, your employer has told you there's an exclusion that they don't plan to remove. The reason for this is a federal law called ERISA, the Employee Retirement Income Security Act, which governs employer-based health plans. If you work for a private employer and you have a self-funded plan, ERISA overrides state law. One thing ERISA does is allow large employers that operate in multiple states to have one employee health plan for all of its employees regardless of what state they're in. So, ERISA says that state insurance law and state nondiscrimination laws don't apply if it's a self-funded plan.

If your plan is insured, however, state insurance law still applies. The way to know which state's law applies is by looking at your plan booklet and seeing what state the plan was issued in.

ERISA itself does not have explicit protections for transgender people, but ERISA does require the plan to be administered according to the terms of the plan. So if there is no exclusion for transgender surgeries, but your care is being improperly denied as "not medically necessary," that is something that can be challenged under ERISA.

How to tell if your plan is self-funded or insured

The remedies that are available to you if there's an exclusion in your plan differ depending on whether it's insured or self-funded.

Sometimes it says right at the beginning of the plan booklet that it's a self-funded, non-insured plan. Otherwise, it requires more detective work and you definitely want to consult with an expert. There is usually a page in the plan document that lists the plan administrator (try searching for "ERISA" to locate it). That page will provide information about if the insurance company is just the claims administrator or if they are acting as an insurer. If it's an insurance plan, oftentimes there will be a group policy number at the beginning of the document. You can also just ask your benefits coordinator which kind of plan it is.

Get the Clinical Criteria

The second document that you need to understand what your plan will cover and what you need to do to get that coverage is your insurance company's medical policy on gender dysphoria treatments. These have many names including Medical Coverage Policy, Clinical Policy Bulletin, UM Guideline, or Clinical Criteria.

A medical policy is the insurance company's internal guidelines for what kind of clinical evidence it wants to see before it will pay a claim. Most of these policies have onerous requirements that are not in line with the World Professional Association of Transgender Health (WPATH) *Standards of Care*. But they provide you a specific roadmap of the information that you need to provide to the insurance company. This is generally one or two letters from a therapist, and these policies outline the content that should be in those letters. They may also have other requirements such as being on hormones for a year or being at least 18 years old to have surgery. If you do not meet the requirements in the clinical policy, that does not mean that you have no hope of getting coverage—you will just have to challenge the denial if you get denied based on that policy.

Click here to download instructions for finding your clinical criteria.

Regardless of whether there is an exclusion or not, the next step you'll want to take is Applying for Coverage so you can see what the insurance company says.

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