Your UnitedHealthcare Benefits Guide

Find transgender and non-binary health resources to support you and your family.

United Healthcare

About this guide

Whether you're considering surgery, you need follow-up care after surgery, need non-surgical services or if you're looking to provide support to your child or other family member, let this guide be your starting point.

Contents

Your UnitedHealthcare Health Advocate team is here for you every step of the way. From providing information about what's covered to helping you make the right care decisions for you and your family, you have an advocate for help and support.

Call us at **1-800-326-9166.**

You have an Advocate

Individuals who have transgender and/or gender affirming health care needs often face disparities in the care they receive. To help navigate what can be a complex and confusing system, UnitedHealthcare has a team of specially trained Advocates to guide you — and your family — through your benefits, coverage and care options.

Our team of highly trained Advocates take ownership of your inquiries and see them through to resolution; assisting not only with gender affirming care, but all of your health needs. Advocates provide compassionate and comprehensive support regardless of where you are on your journey to health and well-being.

Some of the ways our Advocates can provide support:

- Help connect you to medical specialists with expertise in gender dysphoria and gender affirming care
- Engage appropriate clinical resources and assist with claims, referrals and authorizations
- Help you understand the pre-requisites and coverage if you're thinking about or planning gender affirmation surgery
- Work with you to help you receive your medications
- Connect you, and your family, with behavioral health providers to help before, during, or after transitioning, or with other care needs

We're committed to quality care for our members

Let our specialized team help you get the affirming care you deserve. Connect with us Monday – Friday, 8 a.m. – 8 p.m. (local time), at **1-800-326-9166.**

What's covered

Coverage examples include but are not limited to the following. Please call your Advocate team to confirm benefit options.

- Behavioral health services
- Breast/chest surgery*
- Facial/body contouring*
- Gender affirmation surgery*
- Hair-related services, such as electrolysis*
- Hormone therapy*
- Reversal for gender affirmation surgery
- Sexually transmitted disease (STD) and human immunodeficiency virus (HIV) tests
- Travel and lodging:* $10,000 lifetime maximum. Must be using a network provider more than 50 miles from your residence and within the United States.

A full list of covered services is available in the Summary Plan Description, which can be found on the *Clxhub* > *U.S. Total Rewards* > *Health & Welfare Service Center* > *Main Menu* > *Resources* or directly at **cloroxbenefits.com**. Paper copies can be requested by calling **1-833-550-5600.**

Note: Know that these benefits are based on identifiable external sources, including the World Professional Association for Transgender Health (WPATH) standards and/or evidence-based professional society guidance.

Finding network providers

We're here to help you find the right doctor or specialist for you. We can search for transgender- and non-binary-affirming providers. Call us at **1-800-326-9166.**

*Requires prior authorization.

Requirements for gender affirmation surgery

You or your family member must meet all of the following requirements before surgery and/or hair-related services.

1. Persistent, well-documented gender dysphoria
2. Capacity to make a fully informed decision and consent for treatment
3. Must be 18 years of age*
4. If significant medical or mental health concerns are present, these must be reasonably well-controlled
5. Completed 12 months of successful, continuous, full-time, real-life experience in the desired gender
6. Completed 12 months of continuous hormone therapy (for those without contraindications)**
7. Treatment plan must align with current standards of care***

Note: Prior authorization is required for all of these services.

Requirements (1–4) for hair-related services and treatments, including:

- Electrolysis or laser hair removal
- Prescription medications to promote hair growth
- Prescription medications to eliminate hair
- Hair transplantation

* This refers to chronological age, not biological age. Where approval or denial of benefits is based solely on the age of the individual, a case-by-case medical director review is necessary.

** In consultation with the patient's physician, this should be determined on a case-by-case basis through the Notification process.

*** This includes the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

Prescriptions

Optum Rx® is your plan's pharmacy benefits provider

Your pharmacy benefits cover medications such as hormone and hormone blockers intended for gender affirmation as well as HIV prevention, treatment options and more.

To learn more about your prescription benefits:

- Call an Advocate at **1-800-326-9166.**
- Sign in at **myuhc.com®.**
- Download the **UnitedHealthcare® app** to manage your medications on the go.

Getting approvals

All gender affirming care requires a **pre-authorization** submission to determine if a service is covered by your medical plan.

Helpful hint: Call an Advocate to begin the approval process **at least 60 days** before you're planning to have surgery.

Here's how it works:

When you visit a network doctor for care, the physician may identify a service (for example, chest reconstruction) that requires prior authorization.

Your doctor should contact UnitedHealthcare to ask about the proposed service. UnitedHealthcare reviews the request to verify the service is medically necessary* and performed at the appropriate place.

UnitedHealthcare will inform you and your doctor about the approval decision. Together you should review the determination letter and chart out a course of care.

Helpful hint: Reach out to an Advocate if notification hasn't occurred.

What if a service is not approved?

When a service is deemed NOT medically necessary,* you and your provider can choose to agree that you will pay. You will then be responsible for covering costs out of your own pocket.

*Aligned with WPATH standards and/or recognized professional society guidance.

Referrals

Surgical treatments for gender dysphoria can be initiated by a referral from a qualified mental health professional.*

The mental health professional provides documentation — in the chart and/or referral letter — of the patient's personal and treatment history, progress and eligibility.

One referral

This is required from a qualified mental health professional for breast/chest surgery, for example:

- Mastectomy
- Chest reconstruction
- Augmentation mammoplasty

Two referrals

These are required from qualified mental health professionals who have independently assessed the patient for genital surgery, for example:

- Orchiectomy
- Genital reconstructive surgeries
- Hysterectomy/salpingo-oophorectomy

Additional requirements

- If the first referral is from a patient's therapist, the second should be from a person who has only had an evaluative role with the patient
- Two separate letters, or one letter signed by both (for example, if practicing in the same clinic) may be sent
- Each referral letter, however, should cover the same topics in the areas outlined here

*Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

Submitting claims

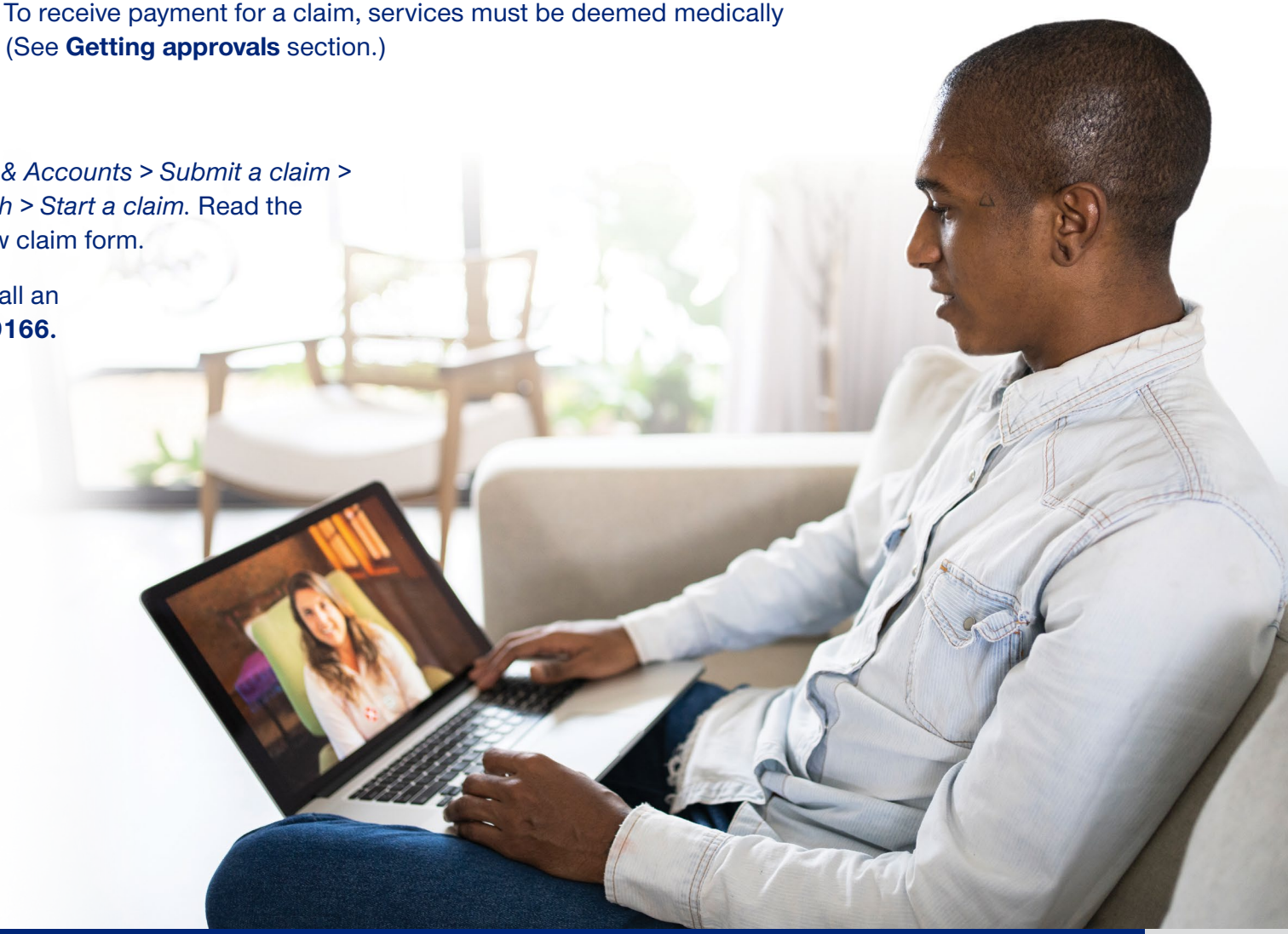
When you receive care from a network provider, the provider will submit claims to UnitedHealthcare on your behalf.

When you receive care from an out-of-network provider, you will need to submit claims to UnitedHealthcare for eligible health care services. To receive payment for a claim, services must be deemed medically necessary by UnitedHealthcare. (See **Getting approvals** section.)

To submit a claim:

Sign in at **myuhc.com** > *Claims & Accounts* > *Submit a claim* > choose *Medical or Mental Health* > *Start a claim*. Read the instructions and select Start new claim form.

If you need assistance, call an Advocate at **1-800-326-9166.**



Behavioral health support

Spring Health Employee Assistance Program (EAP)

Through Spring Health EAP, you have access to a dedicated Care Navigator, well-being assessments, work-life services and on-demand self-help exercises at no cost. The EAP is available to all employees and family household members.

You also have access to **eight therapy sessions per person, per year with costs fully covered by Clorox.**

Call **1-855-629-0554** for immediate assistance or visit **clorox.springhealth.com,** Access code: **clorox**

Behavioral Health Benefits

Tap into your UnitedHealthcare benefits if you have exhausted your eight EAP therapy sessions and/or need longer term care or medication management.

The Clorox Health Plan covers the full range of behavioral health services, from outpatient counseling and psychiatry to in-patient treatment for substance use and other conditions.

Call **1-800-326-9166** to speak with an Advocate or sign in at **myuhc.com** to connect with a counselor virtually. Once signed in, choose *Find Care & Costs* > *Virtual Care* > *Behavioral Health Care* > *Get Started*.

If you are experiencing thoughts about harming yourself, suicide or if this is urgent and an emergency, call 911 or the Suicide and Crisis Lifeline at **988.**

FAQ

Why is it important to use network providers?

Network providers generally:

- Will bill the patient only for any applicable deductible, copay or coinsurance
- Will only bill the patient after the claim processing has been satisfactorily completed
- Submit claims on behalf of members directly to the plan
- Work with the plan to gain the appropriate prior authorizations
- Have passed UnitedHealthcare's accepted credential review and quality requirements
- Will use network facilities, labs and other providers

Out-of-network providers generally:

- Bill patients for any applicable deductible, copay or coinsurance in addition to the difference between their billed amount and the covered amount. This can add up to thousands of additional dollars out of pocket for the patient (called balance billing).
- May require full payment prior to the services being rendered
- Will not submit claims directly to insurance companies, leaving the patient to obtain reimbursement
- Have not passed UnitedHealthcare's accepted credential review and quality requirements
- May use out-of-network facilities, labs or other providers

Note: Facility-based providers, such as radiologists, anesthesiologists and assistant-surgeons are often out-of-network, regardless of whether the primary surgeon is. If a balance bill is received and the service was received at a network facility with a network surgeon, please call an Advocate for assistance.

How do I avoid surprises?

- Stay in contact with an Advocate about upcoming services
- Be aware that using out-of-network providers increases the risk of surprise bills later

FAQ

How can I find a network provider?

Behavioral Health Service — Sign in at **myuhc.com,** choose *Find Care & Costs* and search in the Mental Health directory.

Helpful hint: Use the *Area of Expertise* search tool to identify transgender- and non-binary-affirming providers.

Medical Services — Call an Advocate for assistance.

Hair-Related Services — Call an Advocate for assistance.

What if a network provider is not available?

Contact an Advocate, who will request a Network Gap Exception if a network provider is not available within 50 miles of the patient's home.

A *Network Gap Exception* approval allows the plan to pay claims for approved services at the network level of benefits for providers located more than 50 miles away. It is at the provider's discretion as to whether or not they will agree to a discounted rate, require payment upfront or submit claims directly to the plan.

What if I choose to use an out-of-network provider?

If there are network providers within 50 miles of your home, but you choose to use an out-of-network provider, you will be responsible for costs not covered by your health plan (unless a *Network Gap Exception* is in place).

What is being done to enrich the network in support of transgender-affirming providers?

UnitedHealthcare is reviewing all network providers, which includes contacting offices directly to validate whether new patients are being accepted and whether the providers actively treat patients who are transgender.

What support is available from Advocates?

An Advocate can help with:

- Benefit questions, such as what is covered and how much the plan will pay
- Finding a network provider and coordinating care
- Claim information, such as status, assistance with submission, confirmation of information required
- Authorization, such as status and confirmation of information required

This summary highlights commonly used services and generally indicates how you and a medical plan will cover medical expenses you and/or your enrolled dependents incur. Benefits are provided for covered services that are medically necessary unless otherwise indicated. Some services are subject to annual or lifetime limits. This guide does not reflect all covered services, plan exclusions, limitations, or restrictions. It is not a contract or guarantee of coverage. A full list of covered services is available in the Summary Plan Description, which can be found on *Clxhub > U.S. Total Rewards > Health & Welfare Service Center > Main Menu > Resources* or directly at **cloroxbenefits.com.** Paper copies can be requested by calling **1-833-550-5600.**

This guide, and the benefits it describes, were developed with guidance from evidence-based professional societies, including the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7; refer to **wpath.org** for the current standards of care publication.

Brought to you by UnitedHealthcare for Clorox

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