



Trans Health Project

Working for Transgender Equal Rights

Health Insurance - Applying for Coverage

This section covers how to apply for trans-related health care coverage including:

- [Tips for provider letters](#)
- [Estimating out-of-pocket expenses](#)
- [Considerations when choosing a surgeon](#)
- [Cost warnings for out-of-network surgeons](#)
- [Obtaining preauthorization or reimbursement](#)

Learn more about each step by expanding the buttons below.

If you have not already, be sure to review [Understanding Your Plan](#). If your insurance plan denies coverage, see [Understanding a Denial](#).

Getting Your Provider Letters

Most insurance companies require one or more letters from a mental health provider. They may also want a letter from your hormone provider documenting how long you've been on hormones. And if you're having a surgery that is potentially going to be denied as "cosmetic," getting a letter from your surgeon is also helpful.

Tips for provider letters

When you are asking your provider for a letter, give them a copy of your [insurance company's medical policy](#) and ask them to explain in the letter how you meet all of the insurance company's criteria. If you don't meet the criteria, have them explain why the criteria shouldn't apply to you. While many insurance companies recognize, for example, that being on testosterone is not required before undergoing top surgery, some still may have this listed as a requirement.

Ask your provider to start the letter by listing their own credentials including their education, experience working with trans people, and any relevant training, publications, or professional memberships. Some providers write minimal letters because they don't want to pathologize trans people. But that isn't helpful when it comes to proving that the treatment you need is medically necessary. While there's nothing wrong with being trans, trans people who are seeking access to medical treatment know that there is definitely something about their body that needs to be changed in order to alleviate their gender dysphoria.

We're not yet at the point where trans coverage is automatic, particularly for things like facial surgery and breast augmentation. So the therapist letter shouldn't just say that the person is ready for surgery and understands the risks of the procedure. It should describe how the person has gender dysphoria and list the specific challenges the person faces because of it—such as being depressed, being afraid to leave the house, or needing to wear a binder. The letter should explain that they need to change their sex characteristics in order to alleviate their gender dysphoria. This is medical treatment for a particular diagnosis, and provider letters need to make that clear.

Do I need a therapist letter?

Some people have asked if it's possible to forgo getting a therapist letter. Most insurance company medical policies don't require therapist letters for hormones (except for puberty suppression treatments). If you go to a provider who uses an informed consent model, then it's possible to get hormones without a therapist letter. But for surgery, one therapist letter for top surgery and two letters for bottom surgery is what the WPATH *Standards of Care* currently recommend, so most surgeons and insurance companies follow those requirements.

Estimating Out-of-Pocket Expenses

Even when insurance covers surgery, there can still be significant out-of-pocket expenses. To know what these might be, look at your plan's Summary of Benefits and Coverage chart.

Deductibles

First, find out what the deductible will be. The deductible is the amount you must pay out of pocket before the insurance plan will even start paying benefits. There are usually separate deductibles for in-network and out-of-network care. So even if you've already met your deductible for in-network care, if you choose an out-of-network surgeon, you're going to have to pay the full out-of-network deductible before coverage kicks in.

The good news about a deductible is that once it's met, it's met for all of the care you receive later on in that same plan year. Note that the plan year might not run from January to December. The coverage period will be listed at the top of the Summary of Benefits and Coverage so you'll know on what date the deductible you've already paid resets to zero.

Let's walk through an example. If your surgery costs \$10,000 and you have a \$3,000 deductible, you'd be paying \$3,000 out of pocket if you have not already contributed anything towards your deductible. But then what happens? Is the remaining \$7,000 fully covered? Probably not. This is due to copays or co-insurance.

Copays and co-insurance

A copay is a fixed amount you must pay for certain services. So, your plan may have a \$500 copay for outpatient surgery. Or instead of a copay, you may see that it says "co-insurance" such as 20% co-insurance for in-network services or 40% co-insurance for out-of-network services. "Co-insurance" means that you yourself are partly responsible for paying for the service. It means you pay that 20% or 40% of the cost. While it's rare, you should ask your benefits administrator or HR if your employer has any programs to help cover co-pays and co-insurance costs.

Continuing on from our earlier example, of the remaining \$7,000 after the deductible was paid, you would owe 20% or \$1,400 if the surgeon and the facility were in-network and \$2,800 if they were out-of-network. Note that you can go to an out-of-network surgeon who performs the surgery at an in-network facility or vice versa.

Out-of-pocket limit

The out-of-pocket limit is the maximum you will pay out of pocket in a given plan year. In our example, with the deductible and coinsurance combined, it would be an out-of-pocket cost of \$4,400 for in-network or \$5,800 for out of network. But say there is an out-of-pocket limit of \$3,500 for in-network and \$7,000 for out of network. So that \$4,400 figure? The insurance company can't collect that from you. The most you would pay is \$3,500 if your provider and the facility were both in-network. But if your

provider and the facility were out of network, you'd still be stuck paying the \$5,800. So, you can see how important it is to find a surgeon who is in network or get your out-of-network surgeon to be considered in network. It can mean thousands of dollars difference in the cost of your surgery.

Warning about low out-of-pocket reimbursement

If you pay out of pocket for an out-of-network surgeon, be aware that you will likely be reimbursed a much, much smaller amount than what you paid. This is because insurance companies are allowed to set a "**reasonable and customary**" **charge** for any given service. These amounts are often explicitly tied to Medicare reimbursement rates, which are notoriously low.

If you pay \$10,000 out of pocket, but the insurance company thinks the surgery should have only cost \$5,000, that is the number they will work from. But they will still apply the deductible and any co-insurance amounts, so in the above example, starting from \$5,000 that would mean you would owe the \$3,000 deductible and \$800 co-insurance (40% of the remaining \$2,000), so the insurance company would write you a check for \$1,200 total when you paid \$10,000 out of pocket.

Out-of-network providers are allowed to retain that \$8,800 difference between their fee and what the insurance company reimbursed. In-network providers, however are not allowed to "**balance bill**" for any such difference between what they would charge for a procedure and what the insurance company reimburses. This is why it is important to never pay out of pocket up front if you can avoid it. See the section below, [Using an Out-of-Network Provider](#), for tips on how to do that.

Choosing a Surgeon

We have some resources to help you [find a provider](#) as well as a list of [gender clinics at academic medical centers](#). Asking around in your in-person and on-line support groups is another helpful way to hear first-hand accounts of surgeons in your area.

When choosing a surgeon, find out if the surgeon accepts insurance or not. If they do accept insurance, determine if they're in network or out of network for your plan. To do that, go to your insurance company's website, and search in their "find a doctor" section. Also search for the facility where you'll have your surgery to make sure that's also in network.

Out-of-network surgeons

If the provider is out of network, find out if they will give you the proper paperwork to make it easier for you to be reimbursed by your insurance company. Ideally this means an itemized bill that lists the specific CPT (procedure) codes and the cost broken down for each CPT code. Some surgeons won't help with insurance paperwork at all, which can create unnecessary hurdles when trying to get coverage. Most surgeons now have a person who handles working with insurance companies. That definitely makes things easier on you, so take that into consideration when choosing a surgeon.

See the Estimating Out-of-Pocket Expenses section above for the dangers of paying out of pocket up front. If you must choose an out-of-network provider, see the section below, What To Do if There is No Network Provider, for ways to keep costs down.

Using an Out-of-Network Provider

If you have a plan without out-of-network coverage and there are no qualified in-network providers, the plan must cover an out-of-network provider. Even if you have out-of-network benefits, if there is no in-network provider, you should request that the surgeon be treated as in-network.

As discussed above under [Estimating Out-of-Pocket Expenses](#), sometimes using an out-of-network provider can be almost like not having coverage at all. But if it is your only option, there are steps you can take to minimize your out-of-pocket costs.

Network gap exception

You can call the number on the back of your insurance card to ask about how to go about getting a **network gap exception**. Typically you'll want to get a letter from your surgeon indicating that the procedure is specialized. If you are given a list of supposedly-qualified surgeons from your insurance company, contact them and keep notes about what they say about their experience with trans-related surgery. You can present this information as part of your request to the insurance company.

Single-case agreement

Separately, if you want to use a surgeon who is out-of-network, one way to do this is through a **single-case agreement**. This is a good option where you need to go to an out-of-network surgeon but cannot afford to pay anything up front. Under this arrangement, the surgeon (a "nonparticipating provider") negotiates the reimbursement amount with the insurance company before the surgery. The surgeon is essentially treated as being in-network for your surgery. This avoids you needing to pay anything out of pocket up front and helps to ensure that you won't get any surprise bills afterward. It can sometimes take months for the agreement to be reached, so ask your surgeon's office about this as early as possible.

Applying for Preauthorization or Reimbursement

Once you know the insurance company's criteria and are working on getting your provider letters, you'll want to actually apply for coverage and see what the insurance company says. This process is called getting preauthorization or prior authorization. In Medicare Advantage plans, it's called an "organization determination." You can do this regardless of whether or not your plan excludes trans-related health care. Sometimes the insurance company may deny full benefits if you did not apply for preauthorization, so it's important to do that even if you plan to pay out of pocket initially.

Request it in writing

Calling the insurance company and asking if they cover it will not give you a definitive answer. The people who answer the phones are not given the best training, so they may just tell you it's excluded, or worse, tell you it's covered when it's really not. But even if they tell you it's covered in general, that doesn't mean it will be covered for you specifically. So that's why it's important to get a determination about your particular situation.

Applying for preauthorization results in a formal decision that can be appealed if it's denied. Ideally, you want to have your surgeon apply for preauthorization. If your surgeon does not accept insurance or is unwilling to submit the preauthorization request, you can ask your primary care provider to do it, or you can do it yourself. You can call the number on the back of your card and ask for instructions. You will need to get certain information from the provider and facility to submit the request, typically including their billing contact information, National Provider Identifier (NPI) number, and the specific CPT (procedure) codes for the procedures you will be undergoing.

Submitting a claim for reimbursement

If you've already paid out of pocket, you can submit a claim for reimbursement. Be aware that there are deadlines to file claims, so check your [plan booklet](#) to find the deadline.

It's best if you applied for preauthorization, but you can submit a claim anyway even if you did not. Sometimes there is a penalty for not getting preauthorization, such as being reimbursed \$500 less. Some plans say they won't cover benefits at all if you did not obtain preauthorization.

Insurance companies typically have claim forms that you can submit. If your provider will sign the claim form, that is ideal, but you can still submit the claim even if they will not. You do want to ask your provider for an itemized bill. This lists the diagnosis and CPT (procedure) codes with a breakdown of the cost for each CPT code. Read the instructions on the claim form carefully to provide all of the information required.

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