Be yourself

Transgender and gender-affirming care benefits

Share this information with your doctors so they're aware of your coverage. Your Aetna® benefits cover medically necessary services and are based on the **Standards of Care** published by the World Professional Association for Transgender Health (WPATH). **These benefits include enhancements to the standard Aetna coverage.**

Work with a nurse care manager

To get started, call **860-900-2796 (TTY: 711)** to speak directly with a nurse care manager trained in gender-affirming care. Even if you're not ready to start services yet, you can call now with any questions you may have.

The nurse care manager can be particularly helpful if you have medical questions, want to discuss your treatment plan or need help with procedure approvals. They can:

- Answer your questions, including doing research if needed
- Help you find providers in your area and book appointments
- Handle coordination among the various resources you may need
- Help you understand your plan benefits, such as for surgery, pharmacy and therapy
- Offer other care management support you may not even realize you need
- Support you over time according to your preferences

Please note that you may get the nurse care manager's voicemail if they're assisting other members. At times, they may need to research some of your questions or benefits, but they'll follow up with you shortly.

Your first conversation with a nurse care manager will be by phone. After that, you can choose to communicate by phone or email.

For a high-level overview of your benefits and the services covered, call your Aetna Service Advocate at **1-800-884-9565 (TTY: 711)**.

Policies and plans are insured and/or administered by Aetna Life Insurance Company or its affiliates (Aetna).

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Coverage for gender-affirming care

The Aetna® coverage policies for gender-affirming care (see below) are the standards Aetna uses to determine if you meet criteria for coverage for these services. Your Adobe medical plan provides expanded coverage for the additional services that WPATH recommends. To make sure you understand what's covered, you can ask your nurse care manager to review this information with you.

Medically necessary services covered under Adobe Aetna medical plans:

After receiving preapproval, your coverage includes, but is not limited to:

- Medical services
- Lab services
- Gender-affirming genital surgery
  Coverage policy
- Breast reduction (mastectomy)
  Coverage policy
- Breast augmentation
  Coverage policy
- Hormone therapy
  Coverage policy
- Hair removal (electrolysis/laser)
  Please see page 4 for more information.
- Non-genital, non-breast surgical interventions:
  Coverage policy
  - Liposuction and lipofilling
  - Pectoral implants
  - Facial feminization surgery
  - Voice surgery and thyroid cartilage reduction (tracheal shave)
  - Gluteal augmentation
  - Hair reconstruction
- Voice and communication therapy to develop verbal and non-verbal communication skills

Getting preapproval

Your medical plan requires advance approval (called precertification) for gender-affirming surgery and other covered services. Aetna will review your treatment plan and any medical information your doctor submits to determine if your case meets clinically approved medical guidelines for the proposed services.

Some services may require additional documentation, such as a referral letter from a mental health professional. **Note: The clinical policy bulletins are used to make sure services meet medical criteria, but they don't include everything that's covered by your Adobe Aetna plan.**

This process also allows your doctor to share information with you about how your plan will cover the services in your treatment plan. That way, you'll know before you incur expenses.

If you use an in-network provider, they'll handle precertification for you.

If you use an out-of-network provider, it's not covered under the **AetnaHealthSelect EPO** plan. If you're in the **Aetna HealthSave Basic** plan or **Aetna HealthSave** plan, ask the provider to call Aetna at 1-888-632-3862 (TTY: 711) to start the process. If they don't provide this service, you'll need to call Aetna yourself.

Mental health counseling

You'll need a referral letter from a mental health provider for most care to be covered. No matter where you are on your journey, if you need help finding a mental health provider, you have many options in seeking care under the plan.

Individual, group and family mental health counseling is also covered, based on certain requirements.

To learn more, see **Mental health support on Benefits.Adobe.com**.

Travel and lodging benefits

If covered gender-affirming services are not available from a network provider within 100 miles of your home, your plan will cover U.S. domestic travel and lodging expenses for you and one companion.

Your medical plan deductible and coinsurance apply, as well as these IRS limits and guidelines:

- Travel by, for example, coach class air, train or bus
- Maximum of $50 per person per night, up to $100 per night, for lodging expenses
- Annual combined maximum of $5,000 for gender-affirming, fertility and/or abortion travel and lodging services

Before you travel, you must contact your Aetna Service Advocate at **1-800-884-9565 (TTY: 711)** to verify provider availability. To be reimbursed for travel and/or lodging costs, you must also submit a claim form.

Disability benefits

If you need to take some time off to receive gender-affirming services, you may want to review **Disability benefits on Benefits.Adobe.com**.

Find network providers

For help finding in-network providers who provide gender-affirming services and care, you can ask your nurse care manager for assistance, or use the Aetna provider search tool. Here's how:

- Log in at **Aetna.com** and click on **Find Care & Pricing**.
- When prompted, enter "gender-affirming surgery" or "gender-affirming services" in your search criteria.
- Not all providers list out their specialties in detail, but that doesn't mean they can't provide gender-affirming services. It's best to work with the nurse care manager to find providers for you.
- There may not be a network provider in your area for the service you require. When this happens, it's best to work with the nurse care manager to find providers for you.

The benefits of staying in the network

It's always best to use network providers whenever you can. Here are some of the reasons why:

- You can take advantage of the significant discounts we've negotiated with them.
- Your annual deductible is lower.
- Your coinsurance percentage is lower.
- They'll submit claims and any necessary advance approval (precertification) requests for you.

If there are no network providers in your area

If you can't find a network doctor or facility in your area for a certain service, talk to your nurse care manager. With preapproval, you may be able to use an out-of-network doctor or facility at the in-network benefits level. However, you may need to pay the provider at the time of your visit and submit a claim form to Aetna for reimbursement.

If you're in the **Aetna HealthSelect EPO** plan, there's no coverage when you use out-of-network providers unless it's an emergency.

Hair removal services

For hair removal services to be covered, your provider will need to get preapproval from Aetna by submitting a Gender Affirming Hair Removal Authorization Form. Once approved, hair removal services with the provider designated on the form will be covered for the length of the authorization approval. However, if you switch providers, you'll need to submit an updated authorization form with your new provider information and updated treatment plan.

Since many hair removal providers are not in a medical office, you may need to pay upfront and then submit a claim form to Aetna for reimbursement. You'll need to include an itemized receipt with your claim form, or your reimbursement may be delayed. The receipt must be from your provider and not a copy of your bank statement or credit card bill. **Your nurse care manager can provide details and explain the required forms.**

How to access hair removal services

1. Find a qualified network provider.

- If you need help finding a provider, reach out to your nurse care manager.
- If there aren't any network providers in your area, your chosen provider may qualify for a "network deficiency." This would allow them to charge network pricing, and Aetna would allow the in-network level of benefits. A network deficiency requires preapproval, which your nurse care manager can help you with.

2. Make an appointment with your provider and take:

- The Gender Affirming Hair Removal Authorization Form
- The required referral letter from a mental health professional

3. Obtain preapproval for the services.

- If your provider is in network, they should call Aetna at 1-888-632-3862 (TTY: 711) to begin the process. They'll need to submit the completed form with the referral letter to the contact information on the form.
- If your provider is out of network, you may need to begin the preapproval process yourself. Your nurse care manager can help you. Make sure the form is completed in full ***with*** the clinical information from your provider, and include the required referral letter from a mental health professional if you haven't already submitted it for another service.

For hair removal related to bottom surgery, you most likely will need to go to a dermatologist, depending on your surgeon's recommendation. Generally, for other parts of your body, you can use another type of hair removal professional.

Please be sure to talk with your nurse care manager to ensure the choice of provider matches your surgeon's requirements.

How your plan pays

Your benefits for gender-affirming care are the same as for any other medical care. Here's what your Aetna® medical and integrated pharmacy plan pays for covered services after you meet your annual deductible.

Plan provisions	Aetna HealthSave Basic		Aetna HealthSave		Aetna HealthSelect EPO
	In network	Out of network*	In network	Out of network*	In network
Gender-affirming surgery** Inpatient and outpatient	80%	60%	90%	70%	90%
Mental health office visits	80%	60%	90%	70%	You pay $25 for PCP and mental health visits, not subject to deductible
Other inpatient and outpatient services**	80%	60%	90%	70%	90%
Lab services	80%	60%	90%	70%	You pay $25, not subject to deductible
Prescription drugs (including hormone therapy) You pay the following copays when you use a network pharmacy. For **Aetna HealthSave Basic** and **Aetna HealthSave**: You must meet your deductible before copays apply. You'll pay more if you use an out-of-network pharmacy.* For **Aetna HealthSelect EPO**: You do not need to meet your deductible before copays apply. There's no coverage when you use an out-of-network pharmacy unless it's an emergency.					
Retail or CVS Specialty® pharmacy 30-day supply***	$15 for generics $45 for brand-name drugs on the Aetna Performance Drug List $65 for other brand-name drugs				
Mail order or CVS Pharmacy® 90-day supply***	$30 for generics $90 for brand-name drugs on the Aetna Performance Drug List $130 for other brand-name drugs				

*If you go outside the network (no out-of-network coverage for **Aetna HealthSelect EPO** unless it's an emergency), reimbursement is not based on a negotiated amount, but rather on the recognized amount/charge. You may be responsible for the entire difference between what the provider bills and the recognized amount/charge. And that additional amount doesn't count toward your out-of-pocket maximum.

**All inpatient and certain outpatient services require advance approval (precertification).

***Copays count toward your out-of-pocket maximum.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Refer to Aetna.com for more information about Aetna plans.