MEDICAL COVERAGE POLICY	
SERVICE:	**Gender Affirming Care**
Policy Number:	**064**
Effective Date:	**05/01/2025**
Last Review:	**04/14/2025**
Next Review:	**04/14/2026**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business. Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.*

SERVICE: Gender Affirming Care

PRIOR AUTHORIZATION: Required

POLICY: Not all plans cover this therapy. Coverage for Gender affirming care varies across plans. Of note, there is Texas legislation that limits gender dysphoria care for minors (see the "MANDATES" section of this policy for details). Coverage of drugs for hormonal therapy, as well as whether the drug is covered as a medical or a pharmacy benefit, varies across plans. Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). LCA A53793 from Medicare contractor Palmetto GBA. Medicare NCD or LCD specific InterQual criteria may be used when available. If there are no applicable NCD or LCD criteria, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid Provider Procedures Manual | TMHP (TMPPM). If there are no applicable criteria to guide medical necessity decision making in the TMPPM, use the criteria set forth below.

Medically necessary treatment for an individual with gender dysphoria may include ANY of the following services, when services are available in the benefit plan:

- Behavioral health services
- Hormonal therapy
- Age-related, gender-specific services, including preventive health, as appropriate to the individual's anatomy
- Gender reassignment and related surgery (see below)

BSWHP may consider gender affirming care surgery medically necessary when ALL of the following are met for each specific procedure listed below. Each specific procedure may require additional criteria as listed under the procedure.

A. A letter of referral from a qualified mental health professional
B. Persistent, well-documented gender dysphoria
C. Capacity to make a fully informed decision and to consent for treatment
D. Age 18 years of age or older

E. No significant medical or mental health concerns are present OR if present, they must be reasonably well controlled

Specific procedures that may be considered medically necessary when the above criteria are met and any listed criteria specific to the procedure are met:

A. Reconstructive chest surgery (initial mastectomy or breast augmentation)
B. Gonadectomy (hysterectomy and oophorectomy as appropriate) – must complete six (6) continuous months of hormone therapy as appropriate to the member's gender goals
C. Genital reconstructive surgery (e.g., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female-to-male OR penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male-to-female)
    1. Must complete six (6) continuous months of hormone therapy as appropriate to the member's gender goals (unless medically contraindicated), AND
    2. Must complete six (6) months of living in a gender role that is congruent with their gender identity (real life experience)

Procedures that may be medically necessary for gender reassignment surgery

Female to Male Reconstructive Genital Surgery
Intersex surgery, female to male (may involve staged procedures to form a penis and scrotum using pedicle flaps and free-skin graft, insertion of prostheses and closure of the vagina)
Vaginectomy/colpectomy
Vulvectomy
Metoidioplasty
Phalloplasty (may include nerve transposition of medial or lateral antebrachial nerve)
Hair removal by electrolysis of donor site tissue to be used for phalloplasty, limited to eight 30-minute timed units per day
Penile prosthesis (noninflatable / inflatable), including surgical correction of malfunctioning pump, cylinders, or reservoir
Urethroplasty /urethromeatoplasty
Hysterectomy and salpingo-oophorectomy
Scrotoplasty
Insertion of testicular prosthesis
Replacement of tissue expander with permanent prosthesis testicular insertion
Testicular expanders, including replacement with prosthesis, testicular prosthesis
Flaps, grafts, and/or tissue transfer directly related to a genital reconstructive procedure
Initial mastectomy
Nipple-areola reconstruction (related to mastectomy or post mastectomy reconstruction)
Free full thickness graft (for nipple)
Breast reduction
Pectoral implants

Male to Female Reconstructive Genital Surgery
Intersex surgery, male to female (may involve staged procedures to remove portions of male genitalia and form female external genitals such as penectomy, orchiectomy, vaginoplasty, clitoroplasty, urethroplasty, creation of a vagina)
Vaginoplasty, (e.g, construction of vagina with/without graft, colovaginoplasty, penile inversion)
Hair removal by electrolysis of donor site tissue to be used to line the vaginal canal for vaginoplasty,
Penectomy
Vulvoplasty, (e.g., labiaplasty, clitoroplasty, penile skin inversion)
Urethroplasty
Repair of introitus
Orchiectomy
Flaps, grafts, and/or tissue transfer directly related to a genital reconstructive procedure
Chest surgery: • Initial breast reconstruction including augmentation with implants • Fat grafting (alone, or with implant-based feminization)

The procedures listed below are considered not medically necessary for standard plans. However, some plans may cover some or all of the procedures listed below for gender dysphoria treatment. Check plan documents.

Feminization/Masculinization Procedures
Blepharoplasty
Brow lift
Cheek/malar implants
Chin/nose implants, chin recontouring
Collagen injections, limited to facial
Face lift
Forehead reduction and contouring
Facial bone reduction (osteoplasty)
Jaw reduction, contouring, augmentation
Laryngoplasty
Lip lift and lip filling
Rhinoplasty
Skin resurfacing (e.g., dermabrasion, chemical peels) limited to facial
Thyroid reduction chondroplasty
Neck tightening
Electrolysis other than when performed pre- vaginoplasty as outlined above (i.e., face, neck) and limited to eight 30-minute timed units per day
Suction assisted lipoplasty, lipofilling, and/or liposuction (i.e., head, neck)
Voice therapy/voice lessons

Voice modification surgery

BSWHP considers the following procedures that may be performed as a component of a gender affirming care as cosmetic and therefore not covered (not an all-inclusive list):

Feminization/Masculinization Procedures
Abdominoplasty
Calf implants
Hair transplantation
Suction assisted lipoplasty, lipofilling, and/or liposuction (i.e., body countouring of waist, panniculectomy, thigh, leg, hip, buttock, arm)
Removal of redundant skin
Neck tightening, when not part of a covered facial feminization procedure
Lip enhancement, when not part of a covered facial feminization procedure
Buttock lift/gluteal augmentation
Hair removal (e.g., electrolysis), other than as noted
Laser hair removal, for any indication

BACKGROUND:

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth. The condition is associated with significant distress or impairment in social, school or other important areas of functioning.

The person manifests with the desire to live as a member of the opposite sex and progressively take steps to live in the opposite sex role full-time." Treatment in general, including surgical treatment, aims to help reduce or remove the distressing feelings of a mismatch between biological sex and gender identity.

Gender reassignment surgery, also known as transsexual surgery, sex reassignment surgery or intersex surgery, is the culmination of a series of procedures designed to change the anatomy to conform to the gender to which a person with a gender identity disorder identifies themselves. Gender reassignment surgery entails castration, penectomy and vulva-vaginal construction for male to female gender reassignment. Female to male surgery includes bilateral mammectomy, hysterectomy, salpingo- oophorectomy, followed by phalloplasty and insertion of testicular prosthesis.

MANDATES:

ECFR Title 45, Subtitle A, Subchapter B, Part 156.200e

A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.
SB 14 - Prohibitions on the provision to certain children of procedures and treatments for gender transitioning, gender reassignment, or gender dysphoria and on the use of public money or public assistance to provide those procedures and treatments.

A. The child health plan may not provide coverage for services prohibited by Section 161.702 that are intended to transition a child 's biological sex as determined by the child 's sex organs, chromosomes, and endogenous profiles.
B. For the purpose of transitioning a child 's biological sex as determined by the sex organs, chromosomes, and endogenous profiles of the child or affirming the child 's perception of the child's sex if that perception is inconsistent with the child 's biological sex, a physician or health care provider may not knowingly:
    1. Perform a surgery that sterilizes the child, including, castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, vaginoplasty
    2. Perform a mastectomy.
    3. Provide, prescribe, administer, or dispense any of the following prescription drugs that induce transient or permanent infertility: puberty suppression or blocking prescription drugs to stop or delay normal puberty, supraphysiologic doses of testosterone to females, supraphysiologic doses of estrogen to males, remove any otherwise healthy or non-diseased body part or tissue.

CODES:

Important note:
Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT / HCPCS Codes For procedures that may be medically necessary	11960 - Insertion of tissue expander(s) for other than breast, including subsequent expansion 11970 - Replacement of tissue expander with permanent implant 11971 - Removal of tissue expander without insertion of implant 14041 - Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm 14301 - Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm 14302 - Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure) 14302 - Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure) 15100 - Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050) 15101 - Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) 15200 - Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less 15201 - Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

	15240 - Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less 15241 - Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) 15738 - Muscle, myocutaneous, or fasciocutaneous flap; lower extremity 15750 - Flap; neurovascular pedicle 15757 - Free skin flap with microvascular anastomosis 15771 - Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate 15772 - Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure) 15773 - Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less 17380 - Electrolysis epilation, each 30 minutes 17999 - Unlisted procedure, skin, mucous membrane and subcutaneous tissue 19303 - Mastectomy, simple, complete 19318 - Breast reduction 19325 - Breast augmentation with implant 19340 - Insertion of breast implant on same day of mastectomy (ie, immediate) 19342 - Insertion or replacement of breast implant on separate day from mastectomy 19350 - Nipple/areola reconstruction 53410 - Urethroplasty, 1-stage reconstruction of male anterior urethra 53430 - Urethroplasty, reconstruction of female urethra 53450 - Urethromeatoplasty, with mucosal advancement 54125 - Amputation of penis; complete 54400 - Insertion of penile prosthesis; non-inflatable (semi-rigid) 54401 - Insertion of penile prosthesis; inflatable (self-contained) 54405 - Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir 54520 - Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach 54660 - Insertion of testicular prosthesis (separate procedure) 54690 - Laparoscopy, surgical; orchiectomy 55175 - Scrotoplasty; simple 55180 - Scrotoplasty; complicated 55899 - Unlisted procedure, male genital system 55970 - Intersex surgery; male to female 55980 - Intersex surgery, female to male 56620 - Vulvectomy simple; partial 56625 - Vulvectomy simple; complete 56800 - Plastic repair of introitus 56805 - Clitoroplasty for intersex state 57110 - Vaginectomy, complete removal of vaginal wall 57291 - Construction of artificial vagina; without graft 57292 - Construction of artificial vagina; with graft 57335 - Vaginoplasty for intersex state

	58150 - Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s) 58260 - Vaginal hysterectomy, for uterus 250 g or less 58262 - Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s) 58291 - Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) 58552 - Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) 58554 - Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) 58571 - Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s) 58573 - Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s) 58661 - Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy) 58999 - Unlisted procedure, female genital system (nonobstetrical) C1813 - Prosthesis, penile, inflatable C2622 - Prosthesis, penile, non-inflatable L8600 - Implantable breast prosthesis, silicone or equal C1789 - Prosthesis, breast (implantable)
CPT / HCPCS Codes For procedures that are considered NOT medically necessary for standard plans but may be explicitly covered for some plans. Check plan documents.	11950 - Subcutaneous injection of filling material (eg, collagen); 1 cc or less 11951 - Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc 11952 - Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc 11954 - Subcutaneous injection of filling material (eg, collagen); over 10.0 cc 15780 - Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis) 15781 - Dermabrasion; segmental, face 15782 - Dermabrasion; regional, other than face 15783 - Dermabrasion; superficial, any site (eg, tattoo removal) 15786 - Abrasion; single lesion (eg, keratosis, scar) 15787 - Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure) 15788 - Chemical peel, facial; epidermal 15789 - Chemical peel, facial; dermal 15792 - Chemical peel, nonfacial; epidermal 15793 - Chemical peel, nonfacial; dermal 15820 - Blepharoplasty, lower eyelid 15821 - Blepharoplasty, lower eyelid with extensive herniated fat pad 15822 - Blepharoplasty, upper eyelid 15823 - Blepharoplasty, upper eyelid; with excessive skin weighting down lid 15824 - Rhytidectomy, forehead 15826 - Rhytidectomy; glabellar frown lines 15828 - Rhytidectomy; cheek, chin, and neck 15829 - Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap 15839 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area 15876 - Suction assisted lipectomy; head and neck 17380 - Electrolysis epilation, each 30 minutes

	17999 - Unlisted procedure, skin, mucous membrane and subcutaneous tissue 21120 - Genioplasty; augmentation (autograft, allograft, prosthetic material) 21121 - Genioplasty; sliding osteotomy, single piece 21122 - Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin) 21123 - Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts) 21125 - Augmentation, mandibular body or angle; prosthetic material 21127 - Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft) 21137 - Reduction forehead; contouring only 21138 - Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft) 21139 - Reduction forehead; contouring and setback of anterior frontal sinus wall 21172 - Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts) 21179 - Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material) 21180 - Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts) 21188 - Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts) 21193 - Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft 21208 - Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant) 21209 - Osteoplasty, facial bones; reduction 21210 - Graft, bone; nasal, maxillary or malar areas (includes obtaining graft) 21270 - Malar augmentation, prosthetic material 30400 - Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip 30410 - Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip 30420 - Rhinoplasty, primary; including major septal repair 30430 - Rhinoplasty, secondary; minor revision (small amount of nasal tip work) 30435 - Rhinoplasty, secondary; intermediate revision (bony work with osteotomies) 30450 - Rhinoplasty, secondary; major revision (nasal tip work and osteotomies) 31599 - Unlisted procedure, larynx 31750 - Tracheoplasty; cervical 31899 - Unlisted procedure, trachea, bronchi 40799 - Unlisted procedure, lips 67900 - Repair of brow ptosis (supraciliary, mid-forehead or coronal approach) 92507 - Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
CPT / HCPCS Codes For procedures	15775 - Punch graft for hair transplant; 1 to 15 punch grafts 15776 - Punch graft for hair transplant; more than 15 punch grafts 15825 - Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) 15830 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy 15832 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh

that are viewed as cosmetic and therefore not covered	15833 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg 15834 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip 15835 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock 15836 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm 15837 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand 15838 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad 15839 - Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area wasn't crossed off on other table 15847 - Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure) 15877 - Suction assisted lipectomy; trunk 15878 - Suction assisted lipectomy; upper extremity 15879 - Suction assisted lipectomy; lower extremity 17380 - Electrolysis epilation, each 30 minutes 17999 - Unlisted procedure, skin, mucous membrane and subcutaneous tissue 40799 - Unlisted procedure, lips
ICD-10 Codes	F64.x – Gender identity disorders Z87.890 – Personal history of sex reassignment
ICD-10 Codes Not Covered	

POLICY HISTORY:

Status	Date	Action
New	12/6/2010	New policy
Reviewed	12/6/2011	Reviewed
Reviewed	10/25/2012	Reviewed
Reviewed	10/03/2013	No changes
Reviewed	08/21/2014	No changes
Reviewed	04/30/2015	Added pharmacologic and consultation exclusion.
Reviewed	09/03/2015	Updated to include criteria for coverage where permitted.
Reviewed	07/07/2016	Major revision – update transgender management.
Reviewed	06/13/2017	Updated "Overview" language.
Reviewed	04/24/2018	No changes
Reviewed	10/31/2019	No changes
Updated	05/28/2020	Reviewed and aligned for FirstCare and SWHP.
Reviewed	05/27/2021	Changed name of policy. No content change.
Reviewed	04/21/2022	Reviewed. No changes. Aligned with WPATH 7th version.
Reviewed	04/27/2023	Reviewed. No changes. WPATH version 8 reviewed.
Reviewed	07/27/2023	Significant changes made based on WPATH 8.
Reviewed	06/10/2024	Formatting changes, added hyperlinks to Mandates, CMS, and TMPPM resources, beginning and ending note sections updated to align with CMS requirements and business entity changes. Included SB14 language which prohibits certain procedures and treatment for gender dysphoria in minors.

Reviewed	04/14/2025	No changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available, and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Transsexual Surgery: Its Pros and Cons. Comprehensive Exam Essay. Transsexual Women's Resources. Medical and Other Resources for Transsexual Women (2000) <www.annelawrence com>.Krege, S., Bex, A., et al. Male-to female transsexualism: a technique, results, results and long- term follow-up in 66 patients. Ingentaconnect (2001 September) 88(4): 396- 402(7).
2. Nuttbrock, L., Rosenblum, A., et al. Transgender Identity Affirmation and Mental Health. The International Journal of Transgenderism (2002) 6(4): 1-15.
3. Wagner, I., Fugain, C., et al. Pitch-raising surgery in fourteen male-to-female transsexuals. Laryngoscope (2003 July) 113(7): 1157-1165.
4. Fang, R.H., Chen, T.J., et al. Anatomic study of vaginal width in male-to-female transsexual surgery. Plastic and Reconstructive Surgery (2003 August) 112(2): 511- 514.
5. Hutcheson, Joel. Ambiguous genitalia and intersexuality. May 26, 2004. eMedicine Pediatric Continuing Education. (19 October 2005) <http://www.emedicine.com>
6. Hart, Anita C., and Catherine A. Hopkins. ICD-9-CM Professional for Physicians Volumes I & 2. Salt Lake, Utah: Ingenix (2004 October 1).
7. Rethinking the gender Identity disorder terminology in the Diagnostic and Statistical Manual of Mental Disorders. – Position Paper, Bologna, Italy: HBIGDA Conference (2005 April 7). <http://www avitale.com>.
8. Kanagalingam, J., Georgalas, C., et al. Cricothyroid approximation and subluxation in 21 male-to-female transsexuals. Laryngoscope (2005 April) 115(4): 611-8.
9. Sobralske, M. Primary care needs of patients who have undergone gender reassignment. Journal of the American Academy of Nurse Practitioners (2005 April) 17(4): 133-138.
10. Mayer-Bahlburg, H.F. Introduction: gender dysphoria and gender change in persons with intersexuality. Archives of Sexual Behavior (2005 August) 34(4): 371-373.
11. Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming People. Version 7. 2012 World Professional Association for Transgender Health.
12. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health, 2022, VOL. 23, NO. S1, S1–S258. https://doi.org/10.1080/26895269.2022.2100644
13. World Professional Association for Transgender Health's (WPATH) Standards of Care—Eighth Edition as published: INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH 2022, VOL. 23, NO. S1, S1–S258.

***Note**:*

Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid is offered through Scott and White Health Plan in the Central Texas Medicaid Rural Service Area (MRSA); FirstCare STAR is offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs; and FirstCare CHIP is offered through FirstCare in the Lubbock Service Area.