



Where to Start, What to Ask:

A Guide for LGBT People Choosing Healthcare Plans

Developed by Strong Families and our partners at:

Basic Rights Oregon
Brown Boi Project
Center for American Progress
Equality New Mexico
Family Equality Council
Forward Together
Montana Women Vote
National Center for Lesbian Rights
National Gay and Lesbian Task Force
Raising Women's Voices
SPARK Reproductive Justice Now
Southwest Women's Law Center
Transgender Law Center
Transgender Resource Center of New Mexico
Western States Center
Young Women United



Where to Start, What to Ask: A Guide For LGBT People Choosing Healthcare Plans was developed by Strong Families and our partners at more than fourteen organizations across the country. Strong Families, led by Forward Together, is a national initiative to change how we think, feel, and act about families.

For more information, check out: www.strongfamiliesmovement.org
Follow us on Facebook: facebook.com/strongfamiliesfbpage
On Twitter: [@StrongFams](https://twitter.com/StrongFams)

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So all families can thrive.



NATIONAL CENTER FOR LESBIAN RIGHTS



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Healthcare and the LGBT Community

Strong Families is a national initiative of Forward Together. Strong Families is changing how we think, feel, act, and make policy so that all families can thrive. With more than 110 partners at the local, state, and national level, the movement to support families is growing. We know that families are formed for many reasons and take many forms beyond biological relationships and marriage. Our families include blended families, single parent families, multi-generational families, multi-national families, and lesbian, gay, bisexual, and transgender (LGBT) families. And our policies need to catch up with how our families exist today. At Strong Families, we support policies that recognize all families, promote fairness and opportunity, and expand government programs and services that support family well-being.

That's why we support the Affordable Care Act (ACA)—because we know that the new healthcare law is a critical step toward ensuring that all of our families have the healthcare they need, from reproductive health to dental health to mental health services. Many LGBT individuals and their families have been left out when it comes to health insurance. It has been hard to find coverage that treats our families fairly, covers the care that we need, and doesn't break the bank. Access to affordable health insurance can help address the health disparities that exist because of sexual orientation or gender identity, provide critical preventative care, and ensure that all individuals and families can get the care they need without going bankrupt.

Starting in January 2014, almost everyone in the United States will need to have health insurance



coverage for themselves and their families. Most people already have coverage that satisfies that requirement, including coverage through a job, Medicare, Medicaid, the military, or as an enrolled member of a federally recognized tribe. If you don't have coverage right now or want to get new coverage, you can shop online, over the phone, or in person in your state's health insurance marketplace (sometimes called an "exchange") for a plan that fits your needs. In most states, the marketplace is run by the federal government, but seventeen states¹ have chosen to operate their own marketplace. All marketplaces opened for enrollment on October 1, 2013, and coverage through the marketplaces starts on January 1, 2014.

Three key dates you'll want to mark on your calendar:

- **December 15, 2013:** Last day to sign up in order for coverage to start on January 1, 2014
- **January 1, 2014:** Coverage begins in the health insurance marketplaces
- **March 31, 2014:** Open enrollment ends and last day to enroll to avoid penalty for not having coverage

¹ The seventeen states with state run insurance marketplaces include: CA, CO, CT, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, VT, WA, and Washington DC



Every insurance plan sold through the Health Insurance Marketplaces will have to cover a core set of basic benefits called the “[essential health benefits](#).”² These benefits include a variety of services and medical procedures such as doctor visits, hospital stays, ambulatory care, preventative screenings, prescription drugs, laboratory services, reproductive healthcare, and mental and behavioral health services.

2 www.healthcare.gov/glossary/essential-health-benefits

All health plans are given a [metal status](#)³: bronze, silver, gold, or platinum. These levels describe the level of coverage in each plan, and will impact how much individuals/families pay through deductibles, copays, and insurance. Each metal level has a large number of plans offered by different insurers in your state marketplace. Picking the right metal level of insurance for you and your family is a critical first step in comparing plans.

We’ve created *Where to Start, What to Ask: A Guide for LGBT People Choosing Healthcare Plans* to help individuals and families make informed decisions between the plans offered in the metal level that makes the most sense for you/your family. The guide covers questions to ask Navigators or Assistors in the following areas: definition of family, coverage and cost, mental health services, reproductive health services, coverage for children and/or LGBT youth, transgender healthcare needs, and questions for people living with HIV/AIDS. Use the areas of the guide that you or your family need in assessing healthcare plans in your state.

3 www.out2enroll.org/question/whats-the-difference-between-platinum-gold-silver-and-bronze

Where Can I Get Help?

Navigators, certified application counselors, and insurance agents and brokers can all help with questions about enrollment. The federally run Marketplace has Navigators available 24/7 to help you learn more about health insurance and coverage through healthcare.gov, by phone or chat. For states with a state-based Marketplace, Navigators are also available to help you learn more about the plans in your state. In addition, the healthcare reform law allows organizations to apply to become certified application counselors—including community health centers, AIDS service organizations, local hospitals, and LGBT community organizations in your state.

Navigators and certified assistance counselors can’t discriminate against LGBT people, and federal law requires them to be able to provide appropriate services to diverse groups of people. This means that Navigators should be able to understand issues such as whether plans in the Marketplace offer coverage for domestic partners, how people in same-sex relationships can get the right subsidies and enroll for coverage, and how to work with transgender people to find appropriate coverage options. However, Navigators must be neutral and are not allowed to give you their personal opinion on the right plan or coverage for you.

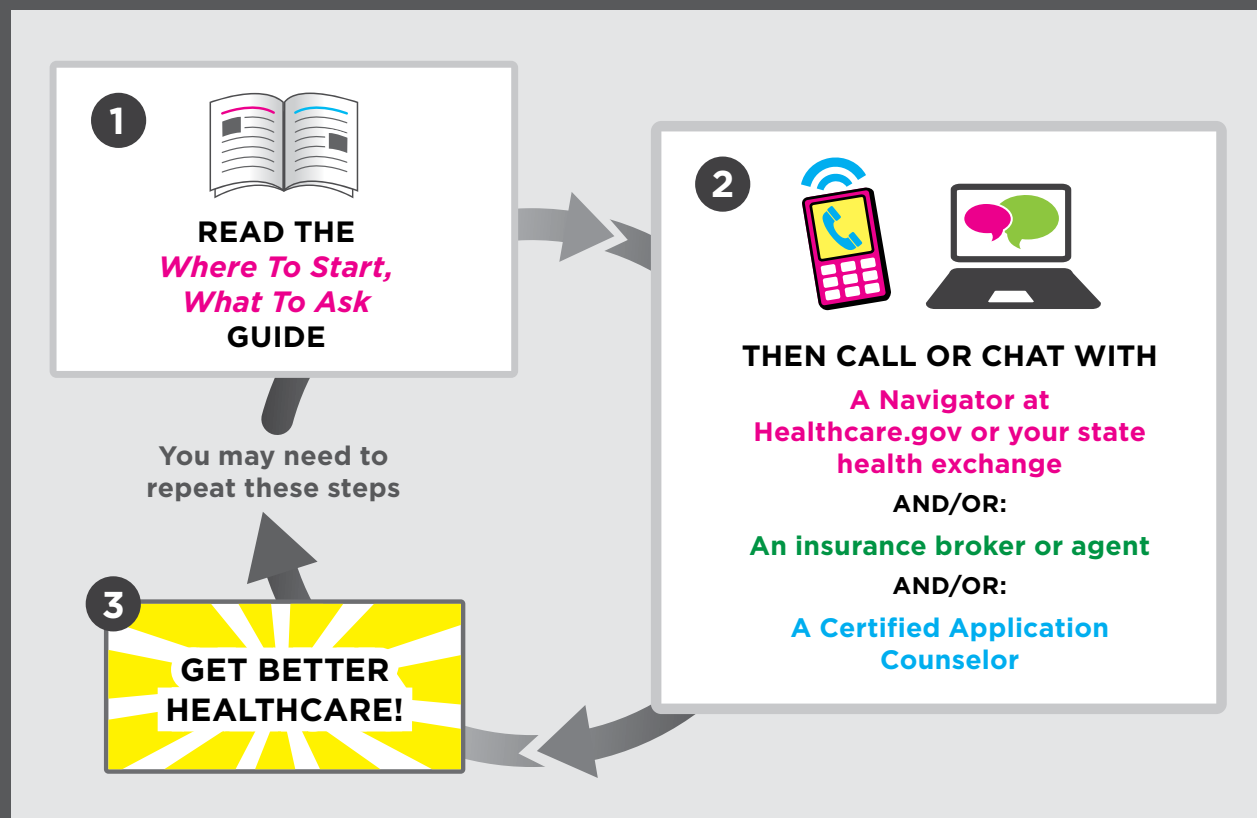
How to Use this Guide

This guide provides a broad overview of questions to consider as you evaluate plans. The guide will serve you best if you have already spent some time thinking about your healthcare needs. By asking yourself questions like: How is your health and how is the health of individuals you want to find coverage for? What kind of coverage do you want—basic or comprehensive coverage? Are you looking to cover certain providers with whom you have pre-existing relationships? Does the plan include the doctor, clinic, or hospital that you currently use? What kind of budget do you have for healthcare? The greater clarity you have about your healthcare needs and budget, the easier talking to a navigator will be.

Once you have greater clarity on your needs, the questions in this guide can help you understand more about what a specific plan offers. Start by reading all the questions. We suggest that everyone seeking healthcare consider asking

questions in **Cost and Coverage, Reproductive Healthcare, and Mental Health**. The other areas—**Definition of Family, LGBT youth, Transgender Healthcare, and HIV/AIDS**—may only apply to you if you are seeking coverage for your same-sex partner or children in your care, or if you identify as a person with healthcare needs in these areas. Look through the questions to see which apply to you and your family, and highlight the questions that you'll want to ask your Navigator.

Finding a healthcare plan can require you to be a strong advocate for yourself and your family. You may need to call a Navigator more than once as you consider the full range of options. Navigators may refer you to specific community organizations that are more knowledgeable about LGBT-specific healthcare needs, or a navigator may suggest you talk to an insurance broker or representative in order to understand



specific details about a plan. You can also use this same list of questions when talking to specific insurance company representatives or community partners.

Throughout the guide, in pink, you will find targeted questions about the ability of providers to understand LGBT issues. Navigators, assistance counselors, or insurance brokers may not be able to answer these questions because this kind of information is not gathered consistently from healthcare providers. However, we included them because we know that these kinds of questions can make a critical difference in creating a trusted relationship with your healthcare provider. For a list of LGBT-knowledgeable healthcare providers, check out the [Gay and Lesbian Medical Association \(GLMA\)](http://www.glma.org)⁴. They keep a list of self-identified providers with experience working with the LGBT community. Once

4 www.glma.org

you identify a provider on the GLMA list, you can ask which plans work for that provider.

If you are a member of a federally recognized tribe or currently receive health services through Indian Health Services (IHS), the healthcare law may give you new options. If you choose to enroll in a health plan through a Marketplace, you may qualify for special benefits and protections offered to American Indians and Alaskan Natives. You can visit the [IHS website](http://www.ihs.gov/aca)⁵ to get more information. If you are a veteran, the [Veteran's Administration](http://www.va.gov/health/aca)⁶ has more information about how the ACA impacts healthcare for veterans and their families. *Where to Start, What to Ask* may still have valuable questions for your current healthcare providers and/or as you evaluate options in the new health insurance marketplaces.

5 www.ihs.gov/aca
6 www.va.gov/health/aca



Cost and Coverage

The questions below can help you figure out what is included in a healthcare plan, what the copays or out-of-pocket expenses are, and what the network of healthcare providers is like. Many of these questions would apply to someone

evaluating a plan of any sexual orientation or gender identity, but we have also included targeted questions about the cultural competency of the providers and network in serving LGBT individuals and their families.

1. How much is the plan going to cost? What are the copays on the plan? Is there a deductible in this plan before coverage kicks in, and what is the amount of the deductible?

2. Is there a wide network of providers on the plan?

- a. If you have a healthcare provider you would like to keep, ask if your provider is covered under the plan.
 - i. If you don't have a current healthcare provider, but would like to find an LGBT-knowledgeable provider, check out the [Gay and Lesbian Medical Association](#)⁷. They keep a list of self-identified providers with experience working with the LGBT community. Once you identify a provider on the GLMA list, you can ask which plans work for that provider.
- b. Can I choose my primary care provider? Can I select a family practice nurse practitioner, midwife, or other kind of clinician as my primary healthcare provider? How many healthcare providers belong to this plan?
- c. What's the referral process within this plan? Do I need to go to my primary care provider to get a referral?

3. Are there providers who specialize in working with LGBT individuals and families? What about with LGBT people of color?

4. Does this plan provide any training about LGBT families and LGBT issues for providers? How does this plan ensure providers

are culturally competent to serve LGBT individuals and their families?

5. Immigration status & language access: To be eligible for health coverage in the health insurance marketplace you must be a U.S. citizen or national living in the U.S. In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

- a. Someone in my family needs language translation to access care. Does the plan provide translators who are both linguistically and culturally competent?

6. How is urgent and emergency care covered in this plan?

- a. Are there urgent care facilities in this plan? What's the cost to me for a visit to urgent care?
- b. What's the cost for a visit to the emergency room in this plan? What about in-network vs. out-of-network?

7. Dental coverage: Dental coverage is not considered an essential health benefit for adults, and insurance plans are not required to offer it as part of plans in the Marketplace. Some Medicaid programs may choose to provide dental benefits and some marketplace health plans may provide dental services as a covered benefit.

- a. Does the plan include dental coverage?

8. Does the plan cover complementary alternative medicine like acupuncture, naturopathic medicine, or chiropractic services?

⁷ www.glma.org



- 9. Smoking:** If you are a smoker or current user of tobacco, you should ask about how this affects the cost of the plan. Generally, an insurer can charge as much as 50% more for a person who uses tobacco products (although CA, MA, RI, VT, and the District of Columbia have prohibited a tobacco surcharge on health insurance). If you report inaccurate or false information about your tobacco use on an application, an insurer is allowed to retroactively impose the tobacco surcharge to the beginning of the plan year.

 - a. I use tobacco products. How does this change the cost of the insurance plan?
 - b. I would like to quit using tobacco products. What kinds of services and programs are available?
- 10. Does the plan cover personal care services?** What about home health services? What is the maximum amount of services allowed?
- 11. Does the plan cover skilled nursing facilities?** What about hospice? What is the maximum amount of these services allowed?
- 12. What kind of rehabilitation services, including physical, speech, and occupational therapy, are covered by the plan?** What are the copays for these services?
- 13. If you have concerns about privacy, you might want to know how billing is handled in each plan.**

 - a. How is billing handled? Which services are explicitly named or billed separately?
- 14. What forms of identification are needed for plan enrollment (driver's license, birth certificate, non-governmental identification)?**

Reproductive Healthcare

In addition to providing general healthcare, all health plans must cover reproductive health services. These services include not only contraceptive services and sexually transmitted infection (STI) screening and treatment, but also screening tests for breast, cervical, and colon cancer, screening for intimate partner violence and support for breastfeeding to name a few. The following is a list of all the preventive services⁸ that all Marketplace health plans must cover without charging you a copayment or coinsurance, even if you haven't met your yearly deductible.

Plans are not required to cover contraceptive services for men, like vasectomies, so it is useful to ask specific questions about these services. For a list of more trans-specific questions, please see the "Transgender Healthcare" section.



⁸ To see a full list of covered preventive reproductive health services, visit www.healthcare.gov/what-are-my-preventive-care-benefits/#part=2

- 15. Annual exams and all methods of contraception that have been approved for sale in the United States (including barrier and hormonal methods, such as rings, pills, patches, and implants, as well as IUDs) are now covered without a copay, co-insurance, or a deductible when they are provided by an in-network provider.** Like all preventive services, contraception (including sterilization/tubal ligation for women) is now covered without charge when prescribed by a clinician. However, insurers might charge a copay for some specific brands of contraception if a generic version is available.
- I prefer to use X brand of birth control. Is there a copay for this brand of contraception?
 - Is vasectomy covered under this plan as a form of birth control? What kind of pre-approval does a vasectomy need? If

vasectomy is not covered, what are the out-of-pocket expenses?

- 16. Clinicians:** You may prefer to see a nurse midwife, nurse practitioner, family doctor, or other clinician for your reproductive healthcare instead of an OB/GYN.
- I would like to keep my current reproductive healthcare provider. Are they covered on this plan?
 - (OR) I prefer to see a midwife or other clinician for my OB/GYN care. How big is the network of providers?
- 17. Fertility coverage:** Does the plan include fertility coverage? If so, what kinds of services (IUI, IVF, surrogacy, medications, and other assisted reproductive technologies) are covered? If the plan includes fertility coverage, be aware that some plans require

a waiting period of six to twelve months, depending on the age of the patient, and the following questions may help:

- a. Is there a waiting period before assisted reproductive technology (ART) services are covered?
- b. Do I have to have a condition of infertility to qualify for ART services? Do I have to have attempted to inseminate or get pregnant without success prior to being covered for ART services?
- c. Are ART services provided to single individuals? Are ART services provided to same-sex couples or couples where one or both of us are transgender? Do couples have to be legally married to be covered for ART services?

18. Fertility coverage options: If the plan I purchase now does not include fertility coverage and I want to purchase coverage for fertility options, how and when may I change plans in the future?

19. Surrogacy: Maternity and newborn care is considered an essential health benefit that must be covered by any insurance plan offered in state marketplaces. Therefore, pregnancy—regardless of how or why a woman becomes pregnant—should ALWAYS be covered.

- a. If I hire a surrogate, can I cover that surrogate on my health plan?

20. Birthing: Will the plan cover home birth or birth at an out-of-hospital birth center? Is there a copay for out-of-hospital or home birth care?

- a. Does the plan provide coverage for birth assistants or doulas?

21. Breastfeeding support and coverage: Health insurance plans are required to cover the cost of a breast pump. Plans may offer to cover either a rental or a new one for you to keep. Plans may provide guidance on whether the covered pump is manual or electric, how long the coverage of rented pumps lasts, and when they'll provide the pump (before or after you have the baby).

- a. What's the coverage for a breast pump—is it a rental or is it purchased? What's the copay for a pump?
- b. Is hormone or lactation therapy covered if a non-birth parent is trying to induce lactation?
- c. **Are there LGBT lactation or trans-friendly lactation consultants available on this plan?**

22. What is included in coverage for post-natal care?

23. Does this plan cover abortion services?

- a. What out-of-pocket expenses would I be responsible for if I choose, or someone covered by the plan chooses, to have an abortion?
- b. Is medication to induce a non-surgical abortion covered on the plan? If not, what is the copay?
- c. How is billing handled for abortion services? Is abortion listed on the bill?

24. I might want to preserve my future fertility by storing eggs and/or sperm. Is fertility preservation (egg or sperm capture, storage, freezing, etc.) covered under this plan?

- a. Is egg harvesting covered in this plan? What is the copay for egg harvesting?
- b. Is ongoing storage covered under this plan or is it the individual's responsibility?
- c. If I am transgender and obtaining transition-related care that will make me infertile, is there coverage for retrieving and storing my eggs/sperm?
- d. To get a hysterectomy, what kind of medical approval or clearance do I need? Will I incur any out-of-pocket expenses?

Mental Health



The ACA expands mental health and substance use disorder benefits, making them an integral part of healthcare and not an add-on. Health plans are now required to cover preventive services like depression screenings for adults and behavioral assessments for children at no additional cost. Starting 2014, insurance companies will no longer be able to deny healthcare coverage to anyone because of a pre-existing mental health condition.

25. Will I have access to therapists who are experienced treating LGBT individuals, their families, and their children?

- a. To find a list of therapists, counselors, psychologists and other mental health professionals who have self-identified expertise in serving the LGBT community, [check out the provider search function at Psychology Today.](#)

26. How is family defined for the purposes of family therapy?

- a. Is couples therapy covered for same-sex couples? Do I need to be married to access couples therapy?

27. How many visits are approved by the plan per year?

28. Is there a copay for mental health services?

How much is the copay for mental health services per visit?

29. Do mental health services include coverage for suicide prevention, bullying, and harassment in schools?

30. What kinds of mental health professionals are covered on the plan?

- a. Specifically, are psychologists, psychiatrists, and licensed clinical social workers, covered on the plan? What other mental health professionals are covered on the plan?

31. Do mental health services include addiction treatment?

- a. Do I need a referral to receive addiction treatment? From whom do I need a referral to receive addiction treatment?
- b. What kind of in-patient and out-patient treatment services are covered?
- c. Is nicotine replacement therapy covered for tobacco cessation?
- d. Is direct counseling covered?

32. What are the mental health benefits for children on the plan?

- a. See "LGBT Kids/Youth" for other specific questions.

Definition of Family

There is no universal definition of “family” within the Affordable Care Act. Therefore, family gets defined at various levels:

- For tax purposes, you will need to look at the IRS definition of family. The IRS will recognize all same-sex marriages for federal tax purposes as long as the couple is married in a state that recognizes their marriage. Married couples must file joint federal income tax returns to be eligible for Advance Premium Tax Credits (APTCs) and Cost



Sharing Reductions (CSRs). Newly released guidelines state that same-sex couples who are legally married in one state can move to a state that does not recognize their marriage and still be eligible for federal-level APTCs/CSRs.

- The state definition of family determines the state subsidy your family may qualify for with Medicaid/CHIP. If a legally married same-sex couple lives in a state that does not recognize their marriage, the state may choose to not recognize their marriage for purposes of Medicaid/CHIP eligibility. As a result, same-sex married couples may have different household sizes for Marketplace- and Medicaid-eligibility determinations, which obviously can create some confusion
- Individual plans: individual health insurance plans available in your state’s insurance marketplace may have varying definitions of family—some may include all members of your household and some may not.

Below are questions to help you figure out how different plans and your state define family. These questions will also help you to understand what documentation you might need in your state to purchase a plan that covers your entire family.

33. Is there a definition of family under my state’s applicable plans?

34. What kind of documentation do I need to apply for coverage for members of my family (marriage certificate, domestic partner registry, birth certificate, etc.)?

35. What’s the definition of family under my state’s applicable plans? Which families qualify?

- a. Can I cover our children, even if I am not a biological parent and have not adopted?
- b. **Am I considered a step-parent under my state’s laws?**
 - i. Can I cover my partner/spouse’s children if I am a stepparent?
- c. If my family doesn’t qualify, and cannot be covered under one comprehensive family plan, how do I apply for a tax credit—at both the federal and state

- level—to cover the cost of having to purchase multiple plans?
- d. Other than children, can I include other family members or members of our household (such as my or my partner/spouse’s parent)?

36. Can I cover my same-sex partner on this health plan?

- a. Can I cover my partner, if we are not legally married or in a legally recognized union (like a civil union or a domestic partnership)?
 - i. If we’re not legally married or in a recognized union, will this plan cover me, and my same-sex partner/spouse, and all of our children? What kind of documentation is accepted by the plan as proof of our relationship?
- b. Given my family composition (spouse/domestic partner/unmarried partner/children/etc.), is my family eligible for either federal or state subsidies to assist with the cost of purchasing insurance through the marketplace?
 - i. If so, do we have to be legally married? What documents are needed?
 - ii. If my partner/spouse is a foreign national, are we eligible for a subsidy?
 - iii. Are there tax ramifications for having my same-sex spouse/partner on this plan?

LGBT Kids/Youth



If you are seeking coverage for a child or person under 26 years old on your health plan, the questions in the “Definition of Family” section will be important to ask. And if a plan covers children, they can be added or kept on that

health insurance policy until they turn 26 years old. If you are a person under the age of 18 seeking healthcare for yourself, at least 34 states allow minors to apply for health insurance without parental consent.

Children for whom you are seeking health coverage may qualify for the Children’s Health Insurance Program (CHIP)⁹, which provides free or low-cost health coverage for children in families with incomes up to \$44,100/year (for a family of four). In many states, families can have higher incomes and their children can still qualify. Each state program has its own rules about who qualifies for CHIP¹⁰. If your children qualify for CHIP coverage, you won’t need to buy a Marketplace plan to cover them.

9 www.insurekidsnow.gov

10 www.healthcare.gov/are-my-children-eligible-for-CHIP

37. If your family meets certain income requirements, children you are trying to cover may qualify for the Children's Health Insurance Program.

- a. Do my children qualify for coverage under CHIP or the state's version of CHIP?

38. Do you have pediatricians and family practitioners who know how to work with LGBT families and youth?

39. Are there doctors in this plan experienced working with gender non-conforming (GNC) or gender variant youth?

40. What kinds of medication or hormone therapy can young people access? Can this therapy be accessed with or without parental involvement?

- a. What kind of mental health "requirements" are necessary to access hormone blockers?
- b. What kind of dermatology drugs/regimens are covered for youth?

41. Are there any providers experienced in working with intersex youth?

42. What counseling and support options are available to parents with LGBT children?

43. What mental health services are available for LGBT youth?

- a. Are mental health services available for trans youth or GNC/gender variant youth?
- b. What suicide prevention counseling is in place?

44. What confidentiality is in place for LGBT youth if they are covered on their parent's plan?

- a. Will I be notified if a minor on this health plan seeks certain services—like birth control, mental health counseling, abortion, or hormone-related therapy?
- b. How does billing happen? What services are outlined on bills?

HIV/AIDS

Starting in 2014, health insurance plans cannot refuse to cover you or charge you more just because you have a pre-existing health condition, including HIV/AIDS. Once you have insurance, the plan cannot refuse to cover treatment for pre-existing conditions and coverage starts immediately. The only exception is for grandfathered individual health insurance plans—the kind you buy yourself, not through an employer. These grandfathered-in plans do not have to cover pre-existing conditions. If you already have one of these kinds of plans, you can switch to a Marketplace plan during open enrollment (Oct. 1, 2013 to March 1, 2014) and immediately get coverage that includes any pre-existing condition.

A note on limits: Under the ACA, insurance companies cannot set a dollar limit on what they

spend on essential health benefits for your care during the entire time you are enrolled in that plan. However, insurance companies can still set a yearly dollar limit of \$2 million on what they spend for your coverage for plan years or policy years starting before January 1, 2014. No yearly dollar limits on essential health benefits are allowed for plan years starting January 1, 2014.

For a list of providers who specialize in care for LGBT individuals with HIV or AIDS, check out the [Gay and Lesbian Medical Association](#)¹¹. They keep a list of self-identified providers with experience working with the LGBT community. Once you identify a provider on the GLMA list, you can ask which plans work for that provider.

¹¹ www.glma.org

45. Does the plan cover PrEP (Pre-Exposure Prophylaxis) drugs for HIV-negative individuals?

- a. Does the plan cover PEP (Post Exposure Prophylaxis) drugs for newly HIV infected individuals?

46. HIV/AIDS Medication coverage: Coverage of specific medications is regulated state by state, and you should ask about the specific drugs covered in your state by brand name to assess if there will be a copay.

47. What kind of testing is covered?

- a. Is blood testing, oral rapid testing, or an in-home rapid testing kit covered?
- b. What's the confidentiality of testing for young people on their parent's plan?

48. What kind of long-term care coverage is part of the plan for people living with AIDS?

Transgender Healthcare

Starting January 1, 2014, health insurance companies can no longer use "pre-existing conditions" as a reason to deny you a coverage plan. For transgender people, this means that having a diagnosis of "gender identity disorder" in your health record can no longer be used as a reason to refuse to sell you a health insurance plan.

With that barrier removed, there are still ongoing questions about what transition-related and gender-specific care you can expect your insurance plan to cover. The ACA's nondiscrimination

section includes protection based on gender identity, so we expect that health plans offered through the state marketplaces will cover some transition-related care, as long as those services are covered for other people on that plan.

Types of care likely to be covered include hormone replacement therapy, gender-specific care (such as mammograms, pap smears, and prostate exams), and organ removal (orchiectomy, hysterectomy/oophorectomy). Mastectomies may be covered, and genital surgeries may or may not be, depending on the plan.

Unfortunately, Navigators and enrollment counselors are unlikely to know the specifics of which benefits are covered in which plans. The best way to find out for sure what will and won't be covered is to look up the plan that your state has used as a "benchmark" for all plans in the exchange, and locate the "Evidence of Coverage" or "Certificate of Coverage" (the full list of covered benefits) for that plan. The Kaiser Family Foundation has compiled a [list of benchmark plans in all 50 states](#)¹².

As you look at the "Certificate of Coverage" or "Evidence of Coverage," the following questions will be useful to consider in comparing plans and selecting the plan that is best for you. If



12 www.kff.org/health-reform/state-indicator/ehb-benchmark-plans

coverage for care related to gender transition is part of what is important for you, keep a close eye out for the “exclusions” and “limitations” on coverage. Exclusions for things like “services related to sex change” or “sex reassignment surgery” indicate that a plan may not offer the kind of coverage you need.

The enrollment process may include completing forms where gender boxes do not correspond to how you identify. We know these boxes may be difficult. Fill these forms out according to the

sex you believe is on file with the Social Security Administration. Physicians should not see the answer to this question, and you should not face denials of coverage for preventive screenings based on your response to this question. If you have questions about how to change the sex on file with the Social Security Administration, the National Center for Transgender Equality has created a guide for trans people and the SSA.¹³

13 www.transequality.org/Resources/SSAResource_June2013.pdf

49. Is hormone therapy covered for individuals on this plan? NOTE: If hormone therapy is covered for anyone on the specific plan you are evaluating, it should be covered for transgender individuals. The ACA makes it illegal for plans to discriminate by offering some people services that they deny to others.

- Is there a limit on hormones or hormone injections? What is the limit?

50. Is there a network of trans-friendly doctors and/or doctors who have training working with or currently serve trans clients?

If you have a current healthcare provider that you would like to keep, ask if that provider is covered by the plan. Is my current healthcare provider covered by the plan?

- If you have a current healthcare provider that you would like to keep, ask if that provider is covered by the plan. Is my current healthcare provider covered by the plan?
- If you don't have a current healthcare provider, but would like to find a trans-friendly provider, check out the [Gay and Lesbian Medical Association](#).¹⁴ They keep a list of self-identified providers with experience working with the LGBT community. Once you identify a provider on the GLMA list, you can ask which plans work for that provider.

- Are there local doctors/doctors within 30 miles who can provide services to transgender individuals?
 - If not, will the plan provide travel reimbursements?

51. Documents Needed to Get Services: What kinds of documents are needed to receive services? Do I need to change my legal ID to receive coverage as a person who is trans identified?

52. Are procedures like facial feminization, breast augmentation, or hair removal covered? What is the copay for these services?

53. Are procedures like breast reductions/mastectomies, chest lifts, and hysterectomies included in the plan? What is the copay for these services?

54. If I am transgender and obtaining transition-related care that will make me infertile, is there coverage for retrieving and storing my eggs/sperm?

14 www.glma.org

Reporting Discrimination

If you have encountered any kind of discrimination, harassment, or judgment in exploring healthcare enrollment options, your rights have been violated. Every person has a right to expect confidential, safe, and non-judgmental services in trying to navigate these new healthcare enrollment organizations.

If you feel you've been treated unfairly, you can make a complaint directly to your state's Health Insurance Marketplace or with the [Office of Civil Rights](#) at the U.S. Department of Health and Human Services. If you receive a denial of coverage for services that should be included under your plan, you have the right to appeal the denial by contacting your insurance company or your state's department of insurance.

A number of LGBT groups are tracking barriers and challenges that LGBT individuals and families experience during enrollment in the ACA

to inform their legal strategies, organizing, and advocacy work. Please consider sharing your experience with organizations like:

Out2Enroll: info@out2enroll.org,
www.Out2Enroll.org

Equality New Mexico: (505) 224-2766,
www.eqnm.org

Family Equality Council: (202) 496-1285,
www.familyequality.org

National Center for Lesbian Rights Helpline:
(800) 528-6257

Southwest Women's Law Center:
(505) 244-0502, www.swwomenslaw.org

Transgender Law Center: (415) 865-0176 x 308,
www.transgenderlawcenter.org

Resource List

NATIONAL RESOURCES

The following list of organizations and websites may be able to offer additional support through the enrollment process.

[Healthcare.gov](#)

Run by the federal government, the National Help Center can connect you, enroll you, help you understand the subsidies available to your family, and direct you to local groups in your state to get additional information.

1 (800) 318-2596 (available 24/7 in different languages)

Greater Than AIDS

This website includes great information for what the ACA means for someone living with HIV. It also has specific information about how the Ryan White HIV/AIDS program and the AIDS

Drug Assistance Program (ADAP) may change with implementation of the ACA.

www.greaterthan.org/campaign/obamacare

Henry Kaiser Family Foundation

The Kaiser Family Foundation has created a great searchable frequently asked questions page. Just enter your key search words to get more information.

www.kff.org/health-reform/faq/health-reform-frequently-asked-questions

Out2Enroll

Out2Enroll is a collaborative effort from the Sellers Dorsey Foundation, the Center for American Progress, and the Federal Agencies Project to educate the LGBT community about their options under the Affordable Care Act.

www.Out2Enroll.org

Family Equality Council

Family Equality Council connects, supports, and represents the three million parents who are lesbian, gay, bisexual, and transgender and their six million children.

(617) 502-8700

www.familyequality.org/get_informed/advocacy/health

Intersex Society of North America

Although INSA has closed its doors, the website contains a wealth of facts and links for individuals looking for additional information about being intersex or raising an intersex child.

www.isna.org

National Gay and Lesbian Task Force

The Task Force works toward a society that values and respects the diversity of human expression and identity and creates equity for all.

(202)639-6316

www.thetaskforce.org

National Women's Health Network (NWHN)

The NWHN's health information program "Women's Health Voice" provides clear, well-researched, and independent information on a variety of women's health topics.

(202) 682-2646, healthquestions@nwhn.org

Tuesday through Friday, 9am-5pm EST

<http://nwhn.org/womens-health-voice>

STATE RESOURCES

Groups listed in specific states have information about their states, but are not able to answer questions about other states.

CALIFORNIA

Transgender Law Center

(415) 865-0176 x 308

www.transgenderlawcenter.org/help

GEORGIA

SPARK Reproductive Justice Now

Conducting outreach activities and providing public education materials for LGBTQ young adults of color, young families, and women of color living in Georgia on the ACA and working with statewide partners to mobilize all Georgians for Medicaid expansion.

(404) 343-6506

www.sparkrj.org

NEW MEXICO

Equality NM

(505) 224-2766

www.eqnm.org

Southwest Women's Law Center

(505) 244-0502

www.swwomenslaw.org

Transgender Resource Center of New Mexico

(505) 200-9086

www.tgrcnm.org

Young Women United

(505) 831-8930

www.youngwomenunited.org

OREGON

Basic Rights Oregon

(503) 222-6151

www.basicrights.org

Cascade AIDS Project

1 (800) 777-AIDS (2437)

www.cascadeaids.org/cover-oregon

Q Center

1 (800) 777-AIDS (2437)

www.pdxqcenter.org/coveroregon

TEXAS

Lesbian Health Initiative of Houston

(713) 426-3356

www.lhihouston.org

