



WELLFLEET
STUDENT

COMPREHENSIVE GUIDE ON GENDER-AFFIRMING SERVICES FOR TRANSGENDER AND NON-BINARY MEMBERS

Enhanced coverage version



Background

Wellfleet Student Health Insurance Plans provide medically necessary gender-affirming services for transgender and non-binary members. This document aims to address common questions regarding coverage, prior authorization criteria, and other services available to support members gender-affirming needs.

This document is intended for marketing purposes only. The information contained herein is non-binding, may vary by plan, and is subject to change. For a complete listing of covered services or procedures, please refer to your Certificate of Coverage available on www.wellfleetstudent.com. You may also contact our Customer Service Department at the number on your Wellfleet ID card.

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Coverage

1. Which gender-affirming services are routinely covered (i.e. do not require Pre-certification)?

- Medical and behavioral health outpatient office visits
- Hormonal treatments
- Laboratory testing
- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individual's biological anatomy
- Speech therapy
- Tracheal shave (chondrolaryngoplasty)

These services are covered when delivered by in-network and out-of-network providers, but Cost-sharing may vary. Refer to *"For covered services, how much out-of-pocket costs will I be responsible for?"* below for more information.

2. Which additional gender-affirming services are covered AFTER Pre-certification?

Top and bottom gender reassignment surgeries, including associated supportive procedures:

- "Top surgery": and associated procedures:
 - Mastectomy
 - Breast reduction
 - Breast augmentation
 - Nipple-areola reconstruction
 - Pectoral implants
 - Skin grafts
- "Bottom surgery" and associated procedures:
 - Hysterectomy
 - Salpingo-oophorectomy
 - Gonadectomy
 - Orchiectomy
 - Genital reconstructive surgery
 - Vaginoplasty
 - Vaginectomy/colpectomy
 - Vulvectomy
 - Metoidioplasty
 - Phalloplasty
 - Scrotoplasty
 - Urethroplasty/urethromeatoplasty
 - Insertion of testicular prosthesis
 - Electrolysis of donor site tissue to be used to line the vaginal canal or male urethra
 - Penectomy
 - Vulvoplasty
 - Repair of introitus
 - Coloproctostomy
 - Electrolysis for skin grafting

Bone reconstruction for facial feminization is covered, but any other ancillary services require additional medical necessity review. These ancillary services include but are not limited to:

- Wrinkle removal
- Nose procedures
- Electrolysis of the face
- Dermabrasion
- Chemical peel
- Eyelid lifts

These services are covered when delivered by in-network and out-of-network providers, but Cost-sharing may vary. Refer to “For covered services, how much out-of-pocket costs will I be responsible for?” below for more information.

3. Which gender-affirming services are not covered?

The following procedures are not covered:

- Electrolysis (hair removal) of chest and/or genital hair, with the exception of electrolysis of skin grafting or donor site tissue to be used to line the vaginal canal or male urethra
- Bone reconstruction for facial masculinization or feminization
- Body sculpting, liposuction, and bone reconstruction other than facial bones

4. What if the service or procedure I am seeking is not listed in this FAQ?

This document is intended for marketing purposes. For a complete listing of covered services or procedures, please refer to your Certificate of Coverage available on www.wellfleetstudent.com. You may also contact our Customer Service Department at the number on your Wellfleet ID card.

The following procedures require special review and Pre-certification, and the rationale for using these codes needs to be provided:

- Procedures with unlisted/unspecified/other codes
- Custom preparation prostheses
- Investigational procedures

Providers may refer to the applicable payment guidelines for more details: <https://wellfleetstudent.com/providers/>.

5. Is fertility preservation covered?

If fertility preservation is a covered benefit for your plan, it is generally covered when a medical treatment will directly or indirectly lead to iatrogenic infertility (i.e. an impairment of your fertility by surgery, radiation, chemotherapy, or other medical treatment affective reproductive organs or processes). Plans vary on whether they include collecting, preserving, and/or storing of ova and sperm. To confirm if your plan covers fertility preservation, please refer to your Certificate of Coverage available on www.wellfleetstudent.com or contact our Customer Service Department at the number on your Wellfleet ID card.

6. What is Pre-certification, and how do I obtain Pre-certification?

Pre-certification is a decision by a health insurer or plan prior to your receipt of a health care service, procedure, treatment plan, prescription drug, or device is medically necessary and/or clinically appropriate. The Certificate of Coverage lists services that require Pre-certification. Pre-certification is often called prior authorization, prior approval, precertification, pre-authorization, or preauthorization. When Pre-certification is required, you must obtain authorization prior to services being delivered. If your school has an Office of Insurance or department within the Student Health Center that helps students obtain services outside the school, first contact them about any specific processes with which they can assist you. Otherwise, to request Pre-certification, you or your provider should complete the [Prior Authorization Request Form](#) available on <https://wellfleetstudent.com/forms/> and send it to Wellfleet via secure transmission:

- Fax: 413-781-1958
- Email: priorauth@wellfleetinsurance.com

Pre-certification ensures that services are medically necessary and appropriate. However, Pre-certification is not a guarantee that benefits will be paid under the health care plan. All benefit determinations are subject to eligibility at the time of service and all terms, limitations, and provisions of the plan document or policy.

7. For covered services, how much out-of-pocket costs will I be responsible for?

Please refer to your Certificate of Coverage available on www.wellfleetstudent.com to determine your Cost-sharing for in-network and out-of-network benefits. Cost-sharing is the same as for any similar non-gender-affirming service (i.e. inpatient surgery, outpatient surgery, therapy). For most plans, search under the word “Gender” to locate applicable services and determine Cost-sharing. You may also contact our Customer Service Department at the number on your Wellfleet ID card.

8. Are surgical complications and revisions covered?

The plan covers surgical complications. However, surgical revisions, such as modification procedures to correct cosmetic issues due to previously approved and performed surgery, not covered as these are part of the risks of surgery and are considered Healthcare Acquired Conditions (HACs).

9. If I receive a covered service that is typically gender-specific (e.g. mammogram, female contraceptives, etc.), will my claim be rejected if I don't identify as male or female?

No. If the service billed generally isn't applicable to the gender on record, Customer Service will research whether the claimant is gender-affirming, and pay the claim appropriately based on the applicable medical needs. If you believe your claim has been inappropriately denied, you may contact our Customer Service Department at the number on your Wellfleet ID card.

10. Are gender-affirming services covered when delivered outside of the United States?

If you are an international student, Wellfleet doesn't cover elective care in your home country. For all other situations, please refer to your Certificate of Coverage available on www.wellfleetstudent.com to determine if there are any restrictions on coverage for medically necessary non-preventative services outside the United States.

If you want to obtain gender-affirming services outside the United States, this would be an out-of-network service and subject to out-of-network Cost-sharing.

Prior Authorization Criteria for Medical Services

11. What requirements do I have to meet to obtain Pre-certification approval for services under the medical benefit?

Prior authorization criteria for gender-affirming services delivered under the medical benefit can be found on the Provider page of our website under "Utilization Review Guidelines" followed by "Gender-Affirming Services": <https://wellfleetstudent.com/providers/>.

The criteria are subject to annual review and update, but it may be updated more frequently based on changes to national standards, clinical best practices, or other factors. For gender-affirming services, we heavily rely on World Professional Association for Transgender Health ("WPATH") guidelines in developing the prior authorization criteria.

Please refer to the following questions in this section for guidelines on services that require Pre-certification.

12. Which requirements must be met for approval of "top surgery" (i.e. mastectomy, breast reduction, or breast augmentation) and associated procedures (e.g. nipple-areola reconstruction, pectoral implants, skin grafts)? Note: Each Applicable procedure needs to be individually requested.

Requirements

- Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master's degree or equivalent), with written documentation submitted to the physician performing the surgery; and
- Age of majority (18 years of age or older)* and
- Capacity to make a fully informed decision and to consent for treatment; and
- Persistent, well-documented gender incongruence; and
- Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it's inconsistent with the patient's desires, goals, or expressions of individual gender identity); and
- Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience); and
- If significant medical or mental health concerns are present, they must be reasonably well controlled as determined by the provider.

*Wellfleet will consider gender-affirming procedures for members under 18 years old, in accordance with state law requirements, but additional prior authorization requirements may apply. For further information, contact

Wellfleet's Clinical Review Team by emailing clinical@wellfleetinsurance.com.

13. What requirements must be met for approval of "bottom surgery" (i.e. hysterectomy and salpingo-oophorectomy, gonadectomy or orchiectomy, and genital reconstructive surgery [vaginoplasty or female-to-male genital reconstructive surgery]) and associated procedures (see list below)?

Associated procedures including but not limited to:

- Vaginectomy/colpectomy
- Vulvectomy
- Metoidioplasty
- Phalloplasty
- Scrotoplasty
- Urethroplasty/urethromeatoplasty
- Insertion of testicular prosthesis
- Electrolysis of donor site tissue to be used to line the vaginal canal or male urethra
- Penectomy
- Vulvoplasty
- Repair of introitus
- Coloproctostomy
- Electrolysis for skin grafting

Note: Each Applicable procedure needs to be individually requested.

Requirements

- Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master's degree or equivalent), with written documentation submitted to the physician performing the surgery; and
- Age of majority (18 years of age or older)* and
- Capacity to make a fully informed decision and to consent for treatment; and
- Persistent, well-documented gender incongruence; and
- Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it's inconsistent with the patient's desires, goals, or expressions of individual gender identity); and
- Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience); and
- If significant medical or mental health concerns are present, they must be reasonably well controlled as determined by the provider.

*Wellfleet will consider gender-affirming procedures for members under 18 years old, in accordance with state law requirements, but additional prior authorization requirements may apply. For further information, contact Wellfleet's Clinical Review Team by emailing clinical@wellfleetinsurance.com.

14. What requirements must be met for approval of bone reconstruction for facial feminization?

- Single letter of referral or recommendation from a qualified, licensed health professional (with minimum of Master's degree or equivalent) with written documentation submitted to the physician performing the surgery; and
- Persistent, well-documented gender incongruence; and
- Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it's inconsistent with the patient's desires, goals, or expressions of individual gender identity); and
- Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience); and
- Capacity to make a fully informed decision and to consent for treatment; and
- Age of majority (18 years of age or older)*; and

- If significant medical or mental health concerns are present, they must be reasonably well controlled.

*Wellfleet will consider gender-affirming procedures for members under 18 years old, in accordance with state law requirements, but additional prior authorization requirements may apply. For further information, contact Wellfleet's Clinical Review Team.

15. What requirements must be met for approval of other ancillary services (i.e. wrinkle removal, nose procedures, electrolysis of the face, dermabrasion, chemical peel, and eye lifts)?

- Two letters of referral or recommendation from qualified, licensed mental health professionals (with minimum of Master's degree or equivalent) with written documentation submitted to the physician performing the surgery. The second referral should be from someone who only has an evaluative role of the individual. Two separate letters, or one letter signed by both, such as when practicing in the same clinic.
 - Letters must clearly state the medical necessity for the procedures; and
- Persistent, well-documented gender incongruence; and
- Documentation of at least 6 months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical or other contraindication or it's inconsistent with the patient's desires, goals, or expressions of individual gender identity); and
- Documentation of 12 months of living in a gender role that is congruent with their gender identity (real life experience); and
- Capacity to make a fully informed decision and to consent for treatment; and
- Age of majority (18 years of age or older)*; and
- If significant medical or mental health concerns are present, they must be reasonably well controlled

*Wellfleet will consider gender-affirming procedures for members under 18 years old, in accordance with state law requirements, but additional prior authorization requirements may apply. For further information, contact Wellfleet's Clinical Review Team.

Gender-Affirming Hormones and HIV PrEP

16. Which gender-affirming hormones are covered?

The July 2023 Wellfleet Rx Student Formulary covers the following gender-affirming hormones:

Label Name	Drug Name	Prior Authorization Required?
ALORA 0.025 MG PATCH	ESTRADIOL	No
ALORA 0.05 MG PATCH	ESTRADIOL	No
ALORA 0.075 MG PATCH	ESTRADIOL	No
ALORA 0.1 MG PATCH	ESTRADIOL	No
ANDRODERM 2 MG/24HR PATCH	TESTOSTERONE	Yes
ANDRODERM 4 MG/24HR PATCH	TESTOSTERONE	Yes
ANDROGEL 1% (25 MG/2.5 G) PKT	TESTOSTERONE	Yes
ANDROGEL 1% (50 MG/5 G) PKT	TESTOSTERONE	Yes
ANDROGEL 1.62% GEL PUMP	TESTOSTERONE	Yes
ANDROGEL 1.62%(1.25G) GEL PCKT	TESTOSTERONE	Yes

ANDROGEL 1.62%(2.5G) GEL PCKT	TESTOSTERONE	Yes
AVEED 750 MG/3 ML VIAL	TESTOSTERONE UNDECANOATE	No
CLIMARA 0.025 MG/DAY PATCH	ESTRADIOL	No
CLIMARA 0.0375 MG/DAY PATCH	ESTRADIOL	No
CLIMARA 0.05 MG/DAY PATCH	ESTRADIOL	No
CLIMARA 0.06 MG/DAY PATCH	ESTRADIOL	No
CLIMARA 0.075 MG/DAY PATCH	ESTRADIOL	No
CLIMARA 0.1 MG/DAY PATCH	ESTRADIOL	No
DELESTROGEN 100 MG/5 ML VIAL	ESTRADIOL VALERATE	No
DELESTROGEN 200 MG/5 ML VIAL	ESTRADIOL VALERATE	No
DELESTROGEN 50 MG/5 ML VIAL	ESTRADIOL VALERATE	No
DEPO-ESTRADIOL 5 MG/ML VIAL	ESTRADIOL CYPIONATE	No
DEPO-PROVERA 150 MG/ML SYRINGE	MEDROXYPROGESTERONE ACETATE	No
DEPO-PROVERA 150 MG/ML VIAL	MEDROXYPROGESTERONE ACETATE	No
DEPO-PROVERA 400 MG/ML VIAL	MEDROXYPROGESTERONE ACETATE	No
DEPO-TESTOSTERONE 100 MG/ML VL	TESTOSTERONE CYPIONATE	Yes
DEPO-TESTOSTERONE 200 MG/ML	TESTOSTERONE CYPIONATE	Yes
DEPO-TESTOSTERONE 200 MG/ML VL	TESTOSTERONE CYPIONATE	Yes
DOTTI 0.025 MG PATCH	ESTRADIOL	No
DOTTI 0.0375 MG PATCH	ESTRADIOL	No
DOTTI 0.05 MG PATCH	ESTRADIOL	No
DOTTI 0.075 MG PATCH	ESTRADIOL	No
DOTTI 0.1 MG PATCH	ESTRADIOL	No
ELESTRIN 0.06% GEL	ESTRADIOL	No
ESTRACE 0.5 MG TABLET	ESTRADIOL	No
ESTRACE 1 MG TABLET	ESTRADIOL	No

ESTRACE 2 MG TABLET	ESTRADIOL	No
ESTRADIOL 0.025 MG PATCH(1/WK)	ESTRADIOL	No
ESTRADIOL 0.025 MG PATCH(2/WK)	ESTRADIOL	No
ESTRADIOL 0.0375MG PATCH(1/WK)	ESTRADIOL	No
ESTRADIOL 0.0375MG PATCH(2/WK)	ESTRADIOL	No
ESTRADIOL 0.05 MG PATCH (1/WK)	ESTRADIOL	No
ESTRADIOL 0.05 MG PATCH (2/WK)	ESTRADIOL	No
ESTRADIOL 0.06 MG PATCH (1/WK)	ESTRADIOL	No
ESTRADIOL 0.075 MG PATCH(1/WK)	ESTRADIOL	No
ESTRADIOL 0.075 MG PATCH(2/WK)	ESTRADIOL	No
ESTRADIOL 0.1 MG PATCH (1/WK)	ESTRADIOL	No
ESTRADIOL 0.1 MG PATCH (2/WK)	ESTRADIOL	No
ESTRADIOL 0.5 MG TABLET	ESTRADIOL	No
ESTRADIOL 1 MG TABLET	ESTRADIOL	No
ESTRADIOL 2 MG TABLET	ESTRADIOL	No
ESTRADIOL 6 MG PELLET	ESTRADIOL	No
ESTRADIOL VALERATE 100 MG/5 ML	ESTRADIOL VALERATE	No
ESTRADIOL VALERATE 200 MG/5 ML	ESTRADIOL VALERATE	No
ESTROGEL 0.06% GEL	ESTRADIOL	No
EVAMIST 1.53 MG/SPRAY	ESTRADIOL	No
FIRST-PROGESTERONE VGS 100 SUP	PROGESTERONE	No
FIRST-PROGESTERONE VGS 200 SUP	PROGESTERONE	No
FORTESTA 10 MG GEL PUMP	TESTOSTERONE	Yes
JATENZO 158 MG CAPSULE	TESTOSTERONE UNDECANOATE	Yes
JATENZO 198 MG CAPSULE	TESTOSTERONE UNDECANOATE	Yes
JATENZO 237 MG CAPSULE	TESTOSTERONE UNDECANOATE	Yes

LYLLANA 0.025 MG PATCH	ESTRADIOL	No
LYLLANA 0.0375 MG PATCH	ESTRADIOL	No
LYLLANA 0.05 MG PATCH	ESTRADIOL	No
LYLLANA 0.075 MG PATCH	ESTRADIOL	No
LYLLANA 0.1 MG PATCH	ESTRADIOL	No
MEDROXYPROGESTERONE 10 MG TAB	MEDROXYPROGESTERONE ACETATE	No
MEDROXYPROGESTERONE 2.5 MG TAB	MEDROXYPROGESTERONE ACETATE	No
MEDROXYPROGESTERONE 5 MG TAB	MEDROXYPROGESTERONE ACETATE	No
MENOSTAR 14 MCG/DAY PATCH	ESTRADIOL	No
MINIVELLE 0.025 MG PATCH	ESTRADIOL	No
MINIVELLE 0.0375 MG PATCH	ESTRADIOL	No
MINIVELLE 0.05 MG PATCH	ESTRADIOL	No
MINIVELLE 0.075 MG PATCH	ESTRADIOL	No
MINIVELLE 0.1 MG PATCH	ESTRADIOL	No
NATESTO NASAL 5.5 MG/0.122 GM	TESTOSTERONE	Yes
PROGESTERONE 500 MG/10 ML VIAL	PROGESTERONE	No
PROVERA 10 MG TABLET	MEDROXYPROGESTERONE ACETATE	No
PROVERA 2.5 MG TABLET	MEDROXYPROGESTERONE ACETATE	No
PROVERA 5 MG TABLET	MEDROXYPROGESTERONE ACETATE	No
STRIANT 30 MG MUCOADHESIVE	TESTOSTERONE	Yes
TESTIM 1% (50MG) GEL	TESTOSTERONE	Yes
TESTONE CIK KIT	TESTOSTERONE CYPIONATE	Yes
TESTOPEL 75 MG PELLETS	TESTOSTERONE	Yes
TESTOSTERON CYP 1,000 MG/10 ML	TESTOSTERONE CYPIONATE	Yes
TESTOSTERON CYP 2,000 MG/10 ML	TESTOSTERONE CYPIONATE	Yes
TESTOSTERON ENAN 1,000 MG/5 ML	TESTOSTERONE ENANTHATE	Yes

TESTOSTERONE 1% (25MG/2.5G) PK	TESTOSTERONE	Yes
TESTOSTERONE 1% (50 MG/5 G) PK	TESTOSTERONE	Yes
TESTOSTERONE 1.62% (2.5 G) PKT	TESTOSTERONE	Yes
TESTOSTERONE 1.62% GEL PUMP	TESTOSTERONE	Yes
TESTOSTERONE 1.62%(1.25 G) PKT	TESTOSTERONE	Yes
TESTOSTERONE 10 MG GEL PUMP	TESTOSTERONE	Yes
TESTOSTERONE 100 MG PELLET	TESTOSTERONE	Yes
TESTOSTERONE 12.5 MG/1.25 GRAM	TESTOSTERONE	Yes
TESTOSTERONE 200 MG PELLET	TESTOSTERONE	Yes
TESTOSTERONE 30 MG/1.5 ML PUMP	TESTOSTERONE	Yes
TESTOSTERONE 50 MG PELLET	TESTOSTERONE	Yes
TESTOSTERONE 50 MG/5 GRAM GEL	TESTOSTERONE	Yes
TESTOSTERONE 50 MG/5 GRAM PKT	TESTOSTERONE	Yes
TESTOSTERONE CYP 1,000 MG/5 ML	TESTOSTERONE CYPIONATE	Yes
TESTOSTERONE CYP 100 MG/ML	TESTOSTERONE CYPIONATE	Yes
TESTOSTERONE CYP 200 MG/ML	TESTOSTERONE CYPIONATE	Yes
TESTOSTERONE CYP 250 MG/5 ML	TESTOSTERONE CYPIONATE	No
TESTOSTERONE CYP 500 MG/2.5 ML	TESTOSTERONE CYPIONATE	Yes
TESTOSTERONE CYP 500 MG/5 ML	TESTOSTERONE CYPIONATE	Yes
TESTOSTERONE CYP 6,000 MG/30ML	TESTOSTERONE CYPIONATE	Yes
TESTOSTERONE ENAN 200 MG/ML	TESTOSTERONE ENANTHATE	Yes
TESTOSTERONE ENANTHATE POWDER	TESTOSTERONE ENANTHATE	No
TESTOSTERONE POWDER	TESTOSTERONE	No
TESTOSTERONE PROP 1,000MG/10ML	TESTOSTERONE PROPIONATE	No
TESTOSTERONE PROPIONATE POWDER	TESTOSTERONE PROPIONATE	No
VIVELLE-DOT 0.025 MG PATCH	ESTRADIOL	No

VIVELLE-DOT 0.0375 MG PATCH	ESTRADIOL	No
VIVELLE-DOT 0.05 MG PATCH	ESTRADIOL	No
VIVELLE-DOT 0.075 MG PATCH	ESTRADIOL	No
VIVELLE-DOT 0.1 MG PATCH	ESTRADIOL	No
VOGELXO 12.5 MG/1.25 GRAM PUMP	TESTOSTERONE	Yes
VOGELXO 50 MG/5 GRAM GEL	TESTOSTERONE	Yes
VOGELXO 50 MG/5 GRAM GEL PACKT	TESTOSTERONE	Yes
XYOSTED 100 MG/0.5 ML AUTO-INJ	TESTOSTERONE ENANTHATE	No
XYOSTED 50 MG/0.5 ML AUTO-INJ	TESTOSTERONE ENANTHATE	No
XYOSTED 75 MG/0.5 ML AUTO-INJ	TESTOSTERONE ENANTHATE	No
ALDACTONE 100 MG TABLET	SPIRONOLACTONE	No
ALDACTONE 25 MG TABLET	SPIRONOLACTONE	No
ALDACTONE 50 MG TABLET	SPIRONOLACTONE	No
CAROSPIR 25 MG/5 ML SUSPENSION	SPIRONOLACTONE	No
SPIRONOLACTONE 100 MG TABLET	SPIRONOLACTONE	No
SPIRONOLACTONE 25 MG TABLET	SPIRONOLACTONE	No
SPIRONOLACTONE 50 MG TABLET	SPIRONOLACTONE	No
CAMCEVI 42 MG SYRINGE	LEUPROLIDE MESYLATE	No
CETRORELIX ACETATE 0.25 MG VL	CETRORELIX ACETATE	No
CETROTIDE 0.25 MG VIAL	CETRORELIX ACETATE	No
ELIGARD 22.5 MG SYRINGE KIT	LEUPROLIDE ACETATE	Yes
ELIGARD 30 MG SYRINGE KIT	LEUPROLIDE ACETATE	Yes
ELIGARD 45 MG SYRINGE KIT	LEUPROLIDE ACETATE	Yes
ELIGARD 7.5 MG SYRINGE KIT	LEUPROLIDE ACETATE	Yes
FENSOLVI 45 MG SYRINGE KIT	LEUPROLIDE ACETATE	Yes
FIRMAGON 2 X 120 MG KIT	DEGARELIX ACETATE	No

FIRMAGON 80 MG KIT	DEGARELIX ACETATE	No
FYREMADEL 250 MCG/0.5 ML SYR	GANIRELIX ACETATE	No
GANIRELIX ACET 250 MCG/0.5 ML	GANIRELIX ACETATE	No
LEUPROLIDE 2WK 14 MG/2.8 ML KT	LEUPROLIDE ACETATE	Yes
LEUPROLIDE DEPOT 22.5 MG VIAL	LEUPROLIDE ACETATE	Yes
LUPANETA PK 11.25-5 MG 3MO KIT	LEUPROLIDE/NORETHINDRONE ACET	Yes
LUPANETA PK 3.75-5 MG 1MO KIT	LEUPROLIDE/NORETHINDRONE ACET	Yes
LUPRON DEPOT 11.25 MG 3MO KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT 22.5 MG 3MO KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT 3.75 MG KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT 45 MG 6MO KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT 7.5 MG KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT-4 MONTH KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT-PED 11.25 MG 3MO	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT-PED 11.25 MG KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT-PED 15 MG KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT-PED 30 MG 3MO KIT	LEUPROLIDE ACETATE	Yes
LUPRON DEPOT-PED 7.5 MG KIT	LEUPROLIDE ACETATE	Yes
MYFEMBREE 40 MG-1 MG-0.5 MG TB	RELUGOLIX/ESTRADIOL/NORETHINDR	No
ORGOVYX 120 MG TABLET	RELUGOLIX	No
SUPPRELIN LA 50 MG KIT	HISTRELIN ACETATE	No
SYNAREL 2 MG/ML NASAL SPRAY	NAFARELIN ACETATE	Yes
TRELSTAR 11.25 MG VIAL	TRIPTORELIN PAMOATE	Yes
TRELSTAR 22.5 MG VIAL	TRIPTORELIN PAMOATE	Yes
TRELSTAR 3.75 MG VIAL	TRIPTORELIN PAMOATE	Yes
TRIPTODUR 22.5 MG KIT	TRIPTORELIN PAMOATE	Yes

VANTAS 50 MG KIT	HISTRELIN ACETATE	Yes
ZOLADEX 10.8 MG IMPLANT SYRN	GOSERELIN ACETATE	Yes
ZOLADEX 3.6 MG IMPLANT SYRN	GOSERELIN ACETATE	Yes
AVODART 0.5 MG SOFTGEL	DUTASTERIDE	No
DUTASTERIDE 0.5 MG CAPSULE	DUTASTERIDE	No
FINASTERIDE 1 MG TABLET	FINASTERIDE	No
FINASTERIDE 5 MG TABLET	FINASTERIDE	No
PROPECIA 1 MG TABLET	FINASTERIDE	No
PROSCAR 5 MG TABLET	FINASTERIDE	No

The formulary may be updated semi-annually. Refer to the formulary applicable to your plan, which can be found under “Current Wellfleet Rx Formularies” on the Wellfleet Rx website: <https://wellfleetrx.com/students/formularies/>.

17. Which requirements do I have to meet to obtain Pre-certification approval for medications under the prescription drug benefit?

Prior authorization criteria for gender-affirming hormones obtained under the prescription drug benefit can be found under “Prior Authorization Guidelines” on the Wellfleet Rx website: <https://wellfleetrx.com/students/formularies/>. Within the Prior Authorization Guidelines, search for the guidelines titled “GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST” or “TESTOSTERONE”, as applicable. Gender-affirming hormones are approved when the prior authorization request is submitted with a gender dysphoria diagnosis; no other clinical requirements must be met. However, Pre-certification is not a guarantee that benefits will be paid under the health care plan. All benefit determinations are subject to eligibility at the time of service and all terms, limitations, and provisions of the plan document or policy.

18. Which HIV PrEP medications are covered?

The Wellfleet Rx Student Formulary covers generic Truvada (emtricitabine/tenofovir) with a quantity limit of 1 tablet per day and Aprelude with a quantity limit of 1 injection every 8 weeks. These medications are covered at no copay, so long as they are not used concurrently with HIV medications for the treatment of HIV.

Refer to the formulary applicable to your plan, which can be found under “Current Wellfleet Rx Formularies” on the Wellfleet Rx website: <https://wellfleetrx.com/students/formularies/>.

19. Can I obtain a 3-month supply of my medication?

The short answer is “it depends”. Days supply limits vary by plan. Some plans limit coverage to 30 days supplies, while other plans limit coverage to 90 days supplies.

Please refer to the “Retail Pharmacy Supply Limits” or “Supply Limits” section of your Certificate of Coverage available on www.wellfleetstudent.com. You may also contact our Customer Service Department at the number on your Wellfleet ID card. Additionally, your pharmacy may attempt to fill a 90 days supply and will advise you if it is permitted or not.

20. Where can I find prior authorization criteria for Gender-Affirming Hormones and HIV PrEP?

Prior authorization criteria for gender-affirming hormones obtained under the prescription drug benefit can be found under "Prior Authorization Guidelines" on the Wellfleet Rx website: <https://wellfleetrx.com/students/formularies/>. Within the Prior Authorization Guidelines, search for the guidelines titled "GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST" or "TESTOSTERONE", as applicable. Gender-affirming hormones are approved when the prior authorization request is submitted with a gender dysphoria diagnosis; no other clinical requirements must be met. In other words, your provider must request a prior authorization, but so long as they confirm they are prescribing the drug for gender-affirming purposes, the request will be approved.

Case Management

21. Can I get assistance to coordinate care or other support related to gender-affirming services?

Yes, Wellfleet offers optional "case management" to members seeking or receiving gender-affirming services. A nurse case manager can help you find providers, coordinate resources, support you with medication management, assist with discharge planning following surgery, and more. Case management is a collaborative and supportive approach.

Wellfleet proactively identifies members that may benefit from case management and may reach out to members to inquire about their interest in case management. Alternatively, members interested in exploring case management as an option may contact our Customer Service Department at the number on your Wellfleet ID card or email clinical@wellfleetinsurance.com.

Glossary of Terms

Certificate of Coverage:

A Certificate of Coverage (CoC) is a contract that lists an individual's health insurance coverage under their insurance plan. The CoC details the health benefits the beneficiary and their dependents have under their plan. Details include exclusions and conditions. Wellfleet CoCs are available on www.wellfleetstudent.com.

Cost-sharing:

The amounts you must pay for covered services, including deductible, copayments, and/or coinsurance. A deductible is the amount you owe before the plan pays for covered services. The deductible applies before any copayments or coinsurance are applied. Note that some plans do not have deductibles, and the deductible may not apply to all covered services. A copayment is a fixed amount you pay directly to a provider for a covered service when you receive the service. A coinsurance is your share of the costs of a covered service, calculated as a percentage of the cost for the service you are required to pay to a provider. For example, if the cost is \$100 and you have a 10% in-network coinsurance, you would owe \$10, which is billed after the visit. Some covered services may require a copayment and other services may require a coinsurance.

HIV PrEP:

PrEP (pre-exposure prophylaxis) is medicine that reduces your chances of getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.

Pre-certification:

A decision by a health insurer or plan prior to your receipt of a health care service, procedure, treatment plan, prescription drug, or device is medically necessary and/or clinically appropriate. The Certificate of Coverage lists services that require Pre-certification. Pre-certification is often called prior authorization, prior approval, precertification, pre-authorization, or preauthorization.



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