

Navigating Gender Affirming Care

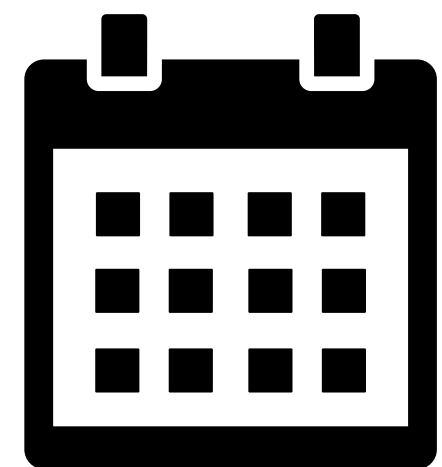
FEHB Plans, Medical Policies, and the Disputed Claims Process

Skylar Cushing (she/her) and Tess Miller (she/her)

December 1, 2021

Agenda

1. Open Season Sign Up Reminder
2. Where to Find Plan Brochures
3. How to analyze FEHB Plan Brochures
4. When and how to reference a plan's Medical Policy
5. Navigating Gender Affirming Care Resource
6. Questions
7. The Disputed Claims Process
8. Final Questions



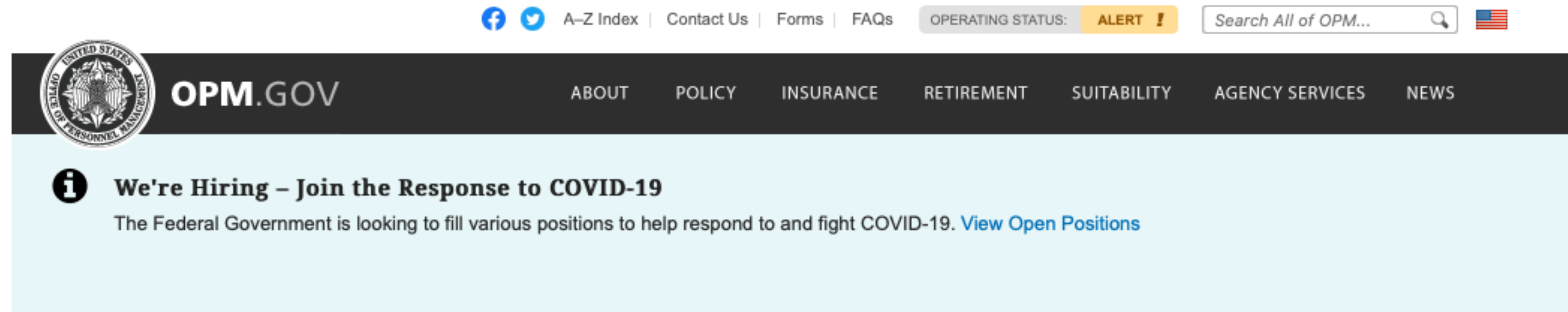
Sign up by December 13



- FEDVIP and FSAFEDS — Monday, December 13, 2021 at 11:59 pm ET
 - You have to actively re-enroll for FSAFEDS each year.
- FEHB— Monday, December 13, 2021 at 11:59 pm in the location of your electronic enrollment system

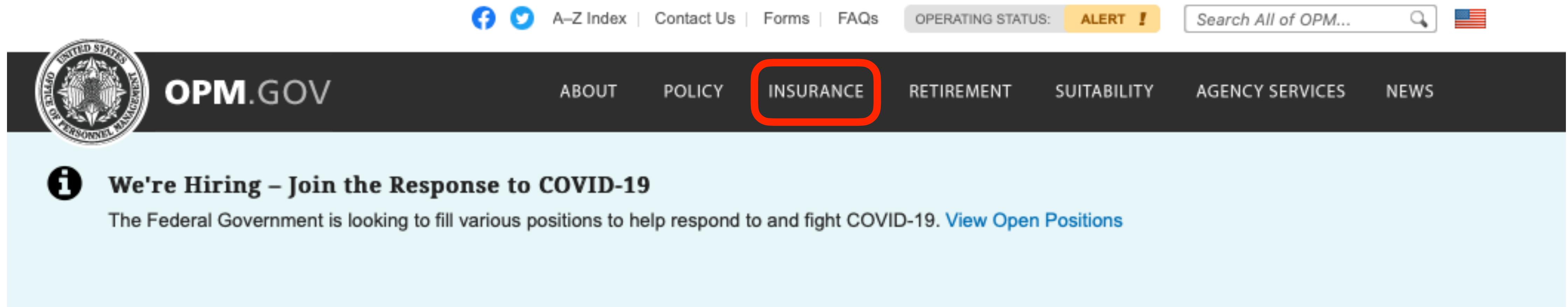
Find Your Available Plan Brochures

- Go to [OPM.gov](https://www.opm.gov)



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The screenshot displays the OPM.GOV website interface. At the top left is the OPM logo, followed by the text "OPM.GOV". A navigation bar contains links for "ABOUT", "POLICY", "INSURANCE", "RETIREMENT", "SUITABILITY", "AGENCY SERVICES", and "NEWS". The "INSURANCE" link is highlighted. Below the navigation bar, the "Healthcare" sub-section is highlighted in a teal bar. The main content area is divided into two columns. The left column features "FEATURED TOPICS" with two items: "FEGLI Handbook" (with a document icon) and "Frequently Asked Questions" (with a question mark icon). The right column lists various insurance topics: "Life Events", "Changes in Health Coverage", "Multi-State Plan Program", "Tribal Employers", "Special Initiatives", "Insurance Glossary", "Insurance FAQs", "Contact Healthcare & Insurance", "The Affordable Care Act", "FEHB Plan Comparison Tool", "Dental & Vision", "FEDVIP Plan Comparison Tool", "Life Insurance", "Flexible Spending Accounts", and "Long Term Care".

OPM.GOV ABOUT POLICY **INSURANCE** RETIREMENT SUITABILITY AGENCY SERVICES NEWS

Healthcare

FEATURED TOPICS

FEGLI Handbook
Review the Federal Employees Group Life Insurance (FEGLI) Handbook

Frequently Asked Questions
Answering your questions about Healthcare and Insurance

Life Events
Changes in Health Coverage
Multi-State Plan Program
Tribal Employers
Special Initiatives
Insurance Glossary
Insurance FAQs
Contact Healthcare & Insurance
The Affordable Care Act
FEHB Plan Comparison Tool
Dental & Vision
FEDVIP Plan Comparison Tool
Life Insurance
Flexible Spending Accounts
Long Term Care

IN THIS SECTION

Life Events 

Changes in Health Coverage 

Healthcare 

Eligibility

Enrollment

Temporary Continuation of Coverage

Medicare

Transparency in Healthcare 

Health Savings Accounts

Consumer Protections


Carriers

Compare Plans 

Plan Types 

Summary of Benefits

Plans 

Enroll 

Guides

Premiums

Previous Years

Compare Quality

Reference Materials 

Healthcare & Insurance

HEALTHCARE

New! FEHB and FEDVIP 2022 Plan Benefit Information Public Use Files.

PUF files provide access to FEHB and FEDVIP Plan, Rate and Benefit Information. [Learn more.](#)

The Federal Employees Health Benefits (FEHB) Program

The FEHB Program can help you and your family meet your health care needs. Federal employees, retirees and their survivors enjoy the widest selection of health plans in the country. You can choose from among Consumer-Driven and High Deductible plans that offer deductibles, health savings/reimbursable accounts and lower premiums, or Fee-for-Service (Organizations (PPO), or Health Maintenance Organizations (HMO) if you live (or sometimes plan.

[Use this site](#) to compare the costs, benefits, and features of different plans. We chose the dif requests, differences among plans, and simplicity. However, we urge you to consider the tota cost, and provider availability when choosing a health plan.

The FEHB [plan brochures](#) show you what services and supplies are covered and the level of cover The brochures are formatted to ensure they are all organized alike. You can get brochures from the office. When it comes to your health care, the best surprise is no surprise.

Pharmacy Incentive Programs and FEHB

Plan Brochure Walkthrough

- OPM Healthcare Plan Information
- BCBS
 - Plan brochure
- Aetna
 - Plan brochure
 - Medical policy
- Keep in mind WPATH Guidelines (SOC v8 due end of December 2021)

Where to Find Gender Affirming Benefits

In FEHB plan brochure

For Surgeries:

- Section 5(b), Reconstructive Surgery
- Beware of keywords such as — “limited to” and “only the following”
- Under the gender affirming benefits, look for exclusions under “not covered.” You may see specific transgender exclusions which could be a list or it could specify all gender affirming services not specifically listed above, or language to that effect.

For Hormones:

- Section 5(f), Prescription Drug Benefits
- Check the insurance’s drug cost tool, easily found under the “Compare Plans” sidebar to verify out of pocket cost for hormones, if needed (Some plans have a flat rate for 30 and 90 day generic)

There are other places where the brochure may discuss gender affirming care (e.g., under medical necessity, pre-certification) and the medical policy, which is external to the brochure.

Mental Health Benefits

- While certainly not unique to gender affirming care, trans*, gender non-conforming, and non-binary people who medically transition will need to consult with a gender therapist to get the necessary referrals for surgeries, and, often, for HRT.
 - There are many informed consent clinics throughout the country. In fact, WPATH allows for the use of prescribing “bridging hormones” which bridges your time between knowing you want to medically transition and being able to be seen by a qualified therapist, psychologist, or psychiatrist.
- Like for surgeons, check the insurance network’s availability of qualified gender therapists in your area. More on this later.

BCBS

<ul style="list-style-type: none">• Gender reassignment surgical benefits are limited to the following:<ul style="list-style-type: none">- For female to male surgery: mastectomy (including nipple reconstruction), hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, electrolysis (hair removal at the covered operative site), and placement of testicular and erectile prosthesis- For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, and electrolysis (hair removal at the covered operative site) <p>Note: Prior approval is required for gender reassignment surgery. For more information about prior approval, please refer to page 22.</p>	See above	See above
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Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	Standard Option	Basic Option
<p>Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria.</p> <ul style="list-style-type: none"> Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. The member must meet all requirements. <ul style="list-style-type: none"> Prior approval is obtained Member must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted Diagnosis of gender dysphoria by a qualified healthcare professional <ul style="list-style-type: none"> New gender identity has been present for at least 24 continuous months Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning 	<p>See page 66</p> <p>This is in excess of WPATH Guidelines</p> <p>DSM-V includes those born intersex and have gender dysphoria a subset of the f64.9 gender dysphoria diagnosis. While gender affirming care is appropriate for them, often the WPATH guidelines are modified to a particular individual</p> <p>This is a DSM-V requirement for Gender Dysphoria Diagnosis</p>	<p>See page 66</p>

- Member must meet the following criteria:
 - Living 12 months of continuous, full-time, real-life experience in the desired gender (including place of employment, family, social and community activities)
 - 12 months of continuous hormone therapy appropriate to the member's gender identity (not required for mastectomy)
 - Two referral letters from qualified mental health professionals – one must be from a psychotherapist who has treated the member for a minimum of 12 months. Letters must document: diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery (one referral letter required for mastectomy)
 - If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled

Reconstructive Surgery - continued on next page

BCBS

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	Standard Option	Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)</i> • <i>Surgeries related to sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)</i> • <i>Reversal of gender reassignment surgery</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Aetna

- Gender affirming surgery* **
 - The Plan will provide coverage for the following when the member meets Plan criteria:
 - Must be 18 years of age
 - Surgical removal of breasts for female-to-male patients
 - Breast augmentation (implants/lipofilling) in male-to-female patients
 - Surgical removal of uterus and ovaries in female-to-male and testes in male-to-female
 - Reconstruction of external genitalia**

- In our review, all Aetna plans cover the same gender affirming benefits in every state

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	Advantage
<p>* Subject to medical necessity based on our clinical policy bulletin. ** Note: Requires Precertification. See Section 3 “Services requiring our prior approval”. You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 888-238-6240.</p> <p>Note: Hormone therapy is covered under Section 5(f), Prescription drug benefits. Prior authorization is required.</p>	<p>In-network: 30% of our Plan allowance</p> <p>Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.</p>
Voluntary sterilization for women (e.g., tubal ligation)	Nothing (no deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgically-induced sterilization</i> • <i>Surgery primarily for cosmetic purposes</i> • <i>Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors</i> • <i>Routine treatment of conditions of the foot (see Foot care)</i> • <i>Gender reassignment services that are not considered medically necessary</i> 	<i>All charges</i>

Medical Policies

- CareFirst BlueChoice
 - Allows for body feminization and body masculinization surgeries that are “generally labeled cosmetic” but “can be considered medically necessary depending on the unique clinically situation of a given patient’s condition.”
- Aetna
 - While the FEHB brochure mentions that covered gender affirming surgeries are subject to their medical policy, the medical policy currently excludes everything not listed in the FEHB brochure.

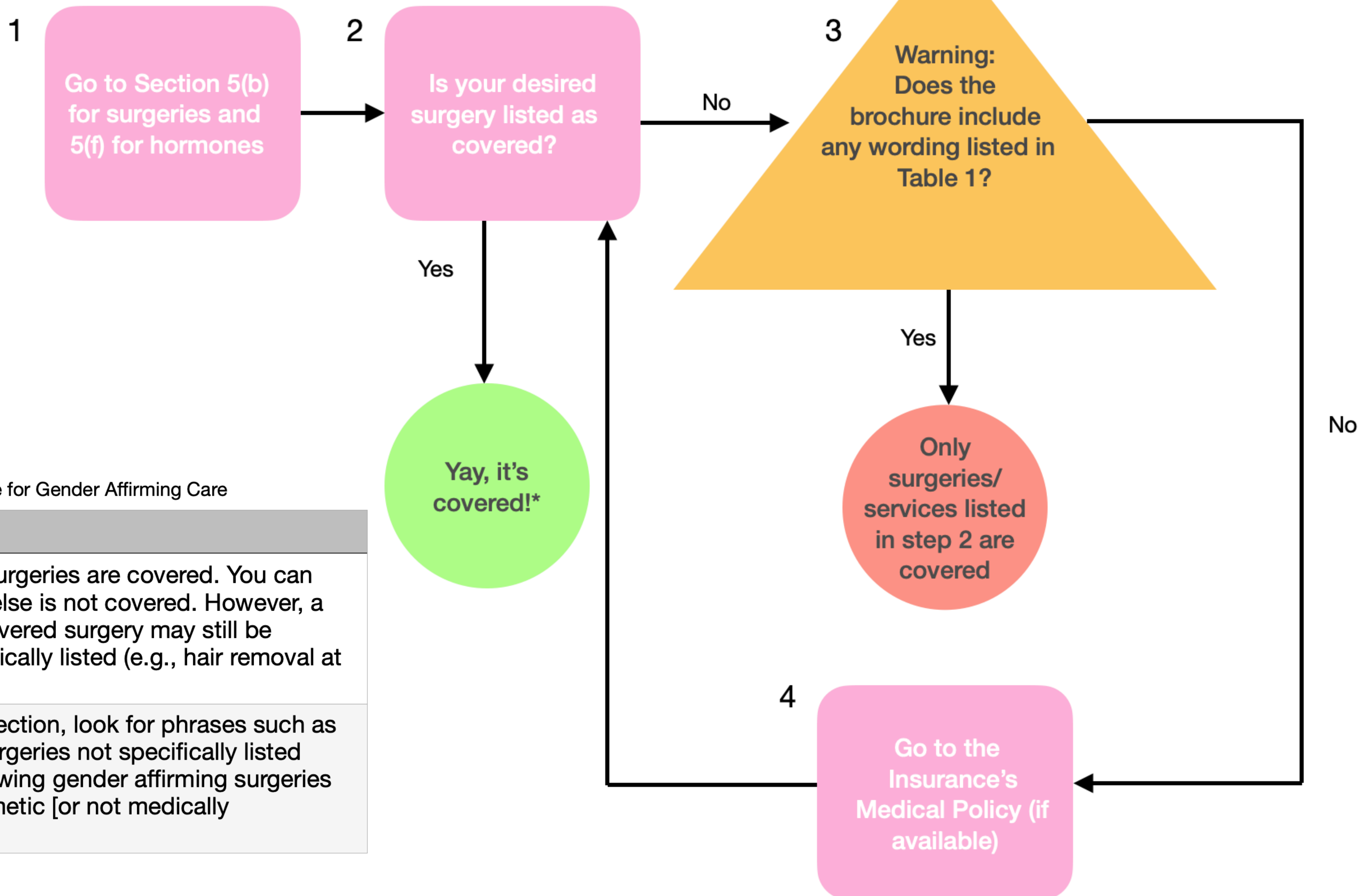


Table 1. Exclusive Language for Gender Affirming Care

Phrase	Meaning
Limited to	Only the following surgeries are covered. You can assume everything else is not covered. However, a requirement for a covered surgery may still be covered if not specifically listed (e.g., hair removal at the surgical site)
Not Covered:	In the not covered section, look for phrases such as “gender affirming surgeries not specifically listed above,” or “the following gender affirming surgeries are considered cosmetic [or not medically necessary]”

Navigating Gender Affirming Care

Spreadsheet Resource by Skylar Cushing with collaboration by Tess Miller

- A community updated guide
- Instructions: This provides instructions on how to use and update the spreadsheet. Provides the resource authorship information
- Plan Your Transition: Currently in its infancy. It has a lot of suggestions based on my experience, research, discussing with others (i.e., social and medical transition logistics)
- National and State Plan Information: tables that list the plans that are available nationally and state-specific. It provides information on gender affirming benefit coverage including medical policies, providing an easy way to compare health plans during open season. It also highlights the disparity between different plans.

Navigating Gender Affirming Care (cont.)

- Online Resources: provides links to community-based trans* resources and advocacy groups that have resources of interest to people going through a social and/or medical transition.
- Find a Gender Therapist: Finding a competent gender therapist in-network of your insurance can be very difficult. This sheet provides two different methods for finding a therapist—Psychology Today and TLDEF's Trans* Health Care Providers.
 - If you are looking for a gender therapist now, verifying your potential plan has several potential gender therapists in-network might not be a bad idea.
 - Shoot them some emails, asking them if they are taking new clients, their experience level, and verifying that they do take insurance still (the insurance provider networks can be outdated).

Requesting Preauthorization

Section 3 in FEHB Plan Brochures

<p>How to request precertification for an admission or get prior authorization for Other services</p>	<p>First, your physician, your hospital, you, or your representative, must call us at 888-238-6240 before admission or services requiring prior authorization are rendered.</p> <p>Next, provide the following information:</p> <ul style="list-style-type: none">• enrollee's name and Plan identification number;• patient's name, birth date, identification number and phone number;• reason for hospitalization, proposed treatment, or surgery;• name and phone number of admitting physician;• name of hospital or facility; and• number of days requested for hospital stay. <p>If the admission is a non-urgent admission or if you are being admitted to a Non-network hospital, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency or an urgent admission, you, the person's physician, or the hospital must get the days certified by calling the number shown on your ID card. This must be done:</p> <ul style="list-style-type: none">• Before the start of a confinement as a full-time inpatient which requires an urgent admission; or• Not later than one (1) business day following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours. <p>If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, you, the physician, or the hospital may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.</p> <p>Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.</p>
<ul style="list-style-type: none">• Non-urgent care claims	<p>For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.</p> <p>If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 45 days from the receipt of the notice to provide the information.</p>

Requesting Preauthorization

Medical Policy Requirements

I. Requirements for Breast Removal

- A. Single letter of referral from a qualified mental health professional (see Appendix); *and*
- B. Persistent, well-documented gender dysphoria (see Appendix); *and*
- C. Capacity to make a fully informed decision and to consent for treatment; *and*
- D. For members less than 18 years of age, completion of one year of testosterone treatment; *and*
- E. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note: A trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy in adults.

II. Requirements for Breast Augmentation (Implants/Lipofilling)

- A. Single letter of referral from a qualified mental health professional (see Appendix); *and*
- B. Persistent, well-documented gender dysphoria (see Appendix); *and*
- C. Capacity to make a fully informed decision and to consent for treatment; *and*
- D. Member is 18 years of age or older; *and*
- E. Completion of one year of feminizing hormone therapy prior to breast augmentation surgery (unless the member has a medical contraindication or is otherwise medically unable to take hormones); *and*
- F. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Requesting Preauthorization

Additional Resources

What types of documents should I send?

You should always discuss with your surgeon what your plan requires for preauthorization and what you (or your doctor) need to submit to them. You will typically have to submit at least two different documents. The first one is a letter from you to your health plan. The second is a letter from your health care provider (typically a mental health or your primary care provider). **Always check the plan documents for specific letter requests.**

Don't know where to start? We can help! Check out the links below for templates and resources you can use.

Always remember to have in hand the specific plan policy on coverage for transition-related care to know the specific requirements that your letter and your doctor's letter should address. You can call your health plan or check your member handbook for this information.

- **Template for writing a letter to your health plan to request preauthorization.** This template will help you create a letter explaining why you need the treatment and why refusing to cover it might be illegal. We'll provide you with an explanation of the law that you can copy right into your letter. The legal explanations will be particularly useful in cases where your plan has a blanket exclusion or an exclusion of a specific procedure. The legal explanations can also be useful to appeal a denial of a preauthorization or claim request.
- **A guide to health care provider letters.** In addition to your own letter, your health care provider should write a letter explaining why the treatment you're seeking is medically necessary for you. Click the link for information on what the letter should typically include and resources for your provider.
- **Templates for people with a self-funded health plan.** This page includes information and templates for people who have a **self-funded health plan**.

Disputing a Prior Authorization Denial

Section 3 in FEHB Plan Brochures

<p>If you disagree with our pre-service claim decision</p>	<p>If you have a pre-service claim and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.</p> <p>If you have already received the service, supply, or treatment, then you have a post-service claim and must follow the entire disputed claims process detailed in Section 8.</p>
<ul style="list-style-type: none">• To reconsider a non-urgent care claim	<p>Within six (6) months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.</p> <p>In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to</p> <ol style="list-style-type: none">1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or2. Ask you or your provider for more information. <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.</p> <ol style="list-style-type: none">3. Write to you and maintain our denial.

Disputing a Preauthorization Denial Cont.

Section 8 Step 1 in FEHB Plan Brochures

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: Aetna Inc., Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.e) Include your email address, if you would like to receive our decision via email. Please note that by providing us your email address, you may receive our decision more quickly. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.</p>

Appealing Denial to OPM

Section 8 Step 3 in FEHB Plan Brochures

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us--if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Appealing Denial to OPM Cont.

Section 8 Step 4 in FEHB Plan Brochures

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Coverage Limiting Phrasing

- “Limited to”
- Excluding gender affirming services not listed as covered
- “Medically necessary”
- * “Cosmetic surgery”

- **Gender reassignment surgical benefits** are limited to the following:

Not covered:

- *Gender affirming surgery, other than the surgeries listed as covered*
- *Reversal of gender affirming surgery*

Not covered:

- Gender affirming services that are not considered medically necessary

Timeline Review

	Submission Due	3rd Party Response Due
Submit Preauthorization	3+ months prior to procedure	15 days
Preauthorization Requiring additional information	45 days from request for additional information	15 days
Reconsideration Request	Within 6 months of preauthorization decision	30 days
Reconsideration Request requiring additional information	60 days from request for additional information	30 days
OPM Appeal	90 days after reconsideration decision	60 days
Legal Action	3* years from OPM decision	N/A

Filing an EEO Complaint against OPM

Discriminatory exclusions based on gender

- Anti-Discrimination Policy
- File within 45 days of reconsideration or OPM decision
- Can be filed simultaneously with appeal to OPM
- Contact an EEO Counselor at your agency
- Mediation and formal hearing options

References

- WPATH Standards of Care, <https://www.wpath.org/publications/soc>
- American Psychiatry Association, Education, Gender Dysphoria Diagnosis (DSM-V criteria for Gender Dysphoria), <https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis>
- Transgender Legal Defense and Education Fund, Trans Health Project, <https://transhealthproject.org>
- Diversity and Inclusion in the Government (DIG) and Pride in Federal Service Collaboration Area at <https://community.max.gov/x/9I0eSw>
- [NCTE's Trans Legal Services Network Directory](#)
- [NCTE's Getting Your Health Care Covered Guide](#)

DC

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Represents transgender clients who have experienced discrimination due to their gender identity in the workplace, at schools or universities, in healthcare settings, or other places of public accommodation.

Pershing Law PLLC

1416 E St NE, Washington DC 20009

202.642.1431 <http://www.pershinglaw.us/>

Stephen B. Pershing, Esq: 202.642.1431 steve@pershinglaw.us

Name and gender marker changes, discrimination

TransLAW

Washington, DC

<https://www.translawdc.org/>

Steering Committee: translawdc@gmail.com

Partners with WWH to run the name and gender marker change clinic and offers financial assistance for individuals changing their identity documents.

NATIONAL

ACLU LGBT & HIV Project

125 Broad St., 18th Floor New York, NY 10004

<https://www.aclu.org/other/about-aclu-lesbian-gay-bisexual-transgender-aids-project>

Chase Strangio, Attorney: 212.549.2500 cstrangio@aclu.org

Human Rights Campaign

1640 Rhode Island Ave. N.W. Washington, DC 20036

<http://www.hrc.org/>

202.628.4160

Lambda Legal

120 Wall St., 19th Floor New York, NY 10005

<http://www.lambdalegal.org>

212.809.8585

National Center for Lesbian Rights

870 Market Street, Suite 370 San Francisco, CA 94102

<http://www.nclrights.org>

Ming Wong, Helpline Attorney: 800.528.6257 mwong@nclrights.org

National Center for Transgender Equality

1400 16th Street NW, Suite 510 Washington, DC 20036

<http://www.transequality.org>

202.745.2314

National LGBTQ Task Force

1325 Massachusetts Ave NW Washington, DC 20005

<http://www.thetaskforce.org>

202.393.5177

Transgender Legal Defense and Education Fund

20 West 20th Street, Ste. 705 New York, NY 10011

<http://www.transgenderlegal.org/>

AC Dumlao, Name Change Project: 646.862.9396 adumlao@transgenderlegal.org

Contacts

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- Tess Miller — seekingtess@gmail.com