Breast Reconstruction

**BREAST AUGMENTATION**

Breast augmentation in transwomen (male to female) is considered medically necessary, and therefore covered, when all of the following criteria are met:

- The individual has persistent, well documented gender dysphoria in accordance with the criteria established in the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition, [DSM-5]
- Breast augmentation is recommended by a qualified professional provider who has consistently monitored the individual up to the time of surgery
  - One referral letter and/or chart documentation must be written from the mental health professional provider who consistently monitored the individual throughout their psychotherapy or any other evaluation to the professional provider who will be responsible for the individual's treatment.
- The individual is at least 18 years of age
- The individual, unless medically contraindicated, has used feminizing hormones continuously and responsibly (which may include screenings and follow-ups with the professional provider) for a 12-month period
- The individual, if required by a mental health professional provider, has regularly participated in psychotherapy throughout the real-life experience at a frequency determined jointly by the individual and the mental health professional provider
- If the individual has significant medical or mental health concerns, they are reasonably well controlled

**Body Contouring**

**POTENTIALLY COSMETIC**

The following procedures are considered potentially cosmetic services, unless medical necessity demonstrating a functional impairment can be identified. Services that are cosmetic are a benefit contract exclusion for all products of the Company, and therefore, not eligible for reimbursement consideration. This is not an all-inclusive list, refer to any applicable medical policies.

- Abdominoplasty
- Blepharoplasty
- Body contouring procedures (e.g., liposuction, lipectomy)
- Botox injections
- Calf implantation
- Cervicoplasty/platysmaplasty
- Chin augmentation (genioplasty, mentoplasty)
- Collagen injections
- Dermabrasions/chemical peels
- Excision of redundant skin
- Facial masculinizing/feminizing surgeries (e.g., facial bone reduction)
- Facial prosthesis (e.g. nasal, orbital)
- Forehead reduction
- Gluteal augmentation (e.g., silicone implants, fat transfer, fat grafting)
- Hair reconstruction (e.g. hair removal/electrolysis, hair transplantation, wigs)
- Injectable dermal fillers (e.g., Sculptra, Radiesse)
- Lip reduction/enhancement
Orthognathic procedures
Otoplasty
Pectoral implantation
Rhinoplasty
Rhytidectomy
Tattooing (non therapeutic)
Trachea shave/reduction thyroid chondroplasty
Voice therapy, voice modification, laryngoplasty, cricothyroid approximation

REQUIRED DOCUMENTATION

The individual's medical record must reflect the medical necessity for the care provided. These medical records may include, but are not limited to: records from the professional provider's office, hospital, nursing home, home health agencies, therapies, and test reports.

Facial Reconstruction

POTENTIALLY COSMETIC

The following procedures are considered potentially cosmetic services, unless medical necessity demonstrating a functional impairment can be identified. Services that are cosmetic are a benefit contract exclusion for all products of the Company, and therefore, not eligible for reimbursement consideration. This is not an all-inclusive list, refer to any applicable medical policies.

- Blepharoplasty
- Body contouring procedures (e.g., liposuction, lipectomy)
- Botox injections
- Calf implantation
- Cervicoplasty/platysmaplasty
- Chin augmentation (genioplasty, mentoplasty)
- Collagen injections
- Dermabrasions/chemical peels
- Excision of redundant skin
- Facial masculinizing/feminizing surgeries (e.g., facial bone reduction)
- Facial prosthesis (e.g. nasal, orbital)
- Forehead reduction
- Injectable dermal fillers (e.g., Sculptra, Radiesse)
- Lip reduction/enhancement
- Orthognathic procedures
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Trachea shave/reduction thyroid chondroplasty

Permanent Hair Removal

POTENTIALLY COSMETIC

The following procedures are considered potentially cosmetic services, unless medical necessity demonstrating a functional impairment can be identified. Services that are cosmetic are a benefit contract exclusion for all products of the Company, and therefore, not eligible for reimbursement consideration. This is not an all-inclusive list, refer to any applicable medical policies. ....

- Hair reconstruction (e.g. hair removal/electrolysis, hair transplantation, wigs)

Voice Therapy And Surgery

POTENTIALLY COSMETIC

The following procedures are considered potentially cosmetic services, unless medical necessity demonstrating a functional impairment can be identified. Services that are cosmetic are a benefit contract exclusion for all products of the Company, and therefore, not eligible for reimbursement consideration. This is not an all-inclusive list, refer to any applicable medical policies. ....

- Voice therapy, voice modification, laryngoplasty, cricothyroid approximation
PUBERTY SUPPRESSING HORMONES
Puberty suppressing hormones (e.g., Supprelin LA® [histrelin acetate], Vantas® [histrelin acetate], Lupron Depot® [leuprolide acetate for depot suspension], Viadur® [leuprolide acetate implant], Eligard® [leuprolide acetate for injectable suspension], Zoladex® [goserelin acetate implant], Trelstar® [triptorelin pamoate for injectable suspension]) are considered medically necessary, and therefore covered, when all of the following criteria are met:

- The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed), in accordance with criteria established in the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition, [DSM-5]
- The individual has reached at least Tanner Stage 2 of development
- Gender dysphoria emerged or worsened with the onset of puberty
- Puberty suppressing hormones are recommended by a qualified professional provider who has consistently assessed the adolescent
  - One referral letter and/or chart documentation for hormone therapy is required from a qualified professional provider
- If the adolescent has significant medical or mental health concerns, they are reasonably well controlled

Note: Subject to the terms, conditions, and limitations of the member’s contract, oral and self-administered hormones are not covered under the medical benefit.

CONTINUOUS HORMONE REPLACEMENT THERAPY
Continuous hormone replacement therapy (e.g., testosterone enanthate, testosterone pellet, estradiol valerate or medroxyprogesterone acetate) for the treatment of gender dysphoria, is considered medically necessary, and therefore, covered when all of the following criteria are met:

- The individual has persistent, well documented gender dysphoria diagnosed in accordance with the criteria established in the Diagnostic and Statistical Manual of Mental Disorders – Fifth edition [DSM-5]
- Continuous hormone replacement therapy is recommended by a qualified professional provider who has consistently assessed the individual
  - One referral letter and/or chart documentation for hormone therapy is required from a qualified professional provider
- If the individual has significant medical or mental health concerns, they are reasonably well controlled

Note: Subject to the terms, conditions, and limitations of the member’s contract, oral and self-administered hormones are not covered under the medical benefit.