Breast Reconstruction

Gender affirming/reassignment surgery will be covered for members greater than or equal to 18 years of age.

The request must be accompanied by letters from two qualified New York State (NYS) licensed health professionals, acting within the scope of his/her practice, who have independently assessed the member and are referring the member for the surgery.

One letter must be from a psychiatrist, psychologist, psychiatric nurse practitioner (NP) or licensed clinical social worker (CSW) with whom the member has an established and ongoing relationship.

The other letter may be from a psychiatrist, psychologist, physician, psychiatric NP or licensed CSW who has only an evaluative role with the member.

Together, the letters must establish that the member:

1. Has a persistent and well-documented case of gender dysphoria
2. Has received hormone therapy (not prerequisite for mastectomy) appropriate to member’s gender goals for a minimum of 12 months prior to seeking genital surgery (unless medically contraindicated or the member is otherwise unable to take hormones)
3. Has lived 12 months in gender role congruent with member’s gender identity (inclusive of binary and Nonbinary Gender) and has received mental health counseling, as deemed medically necessary, during that time
4. Has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery, or if so, that those are reasonably well-controlled prior to the gender reassignment surgery
5. Has the capacity to make fully informed decisions and consent to treatment

Breast augmentation is considered medically necessary provided that the member has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the member is otherwise unable to take hormones.

Body Contouring

Coverage is not available for any surgeries, services or procedures that are purely cosmetic (i.e., when performed solely to enhance appearance, but not to medically treat the underlying gender dysphoria). The following surgery, services and procedures will be reviewed on a case by case basis. It is expected that the clinical rationale for each requested procedure is specifically documented in the letter of medical necessity from the treating physician:

... Liposuction

Facial Reconstruction

Coverage is not available for any surgeries, services or procedures that are purely cosmetic (i.e., when performed solely to enhance appearance, but not to medically treat the underlying gender dysphoria). The following surgery, services and procedures will be reviewed on a case by case basis. It is expected that the clinical rationale for each requested procedure is specifically documented in the letter of medical necessity from the treating physician:

1. Abdominoplasty, blepharoplasty, neck tightening or removal of redundant skin

3. Breast, brow, face or forehead lifts
4. Calf, cheek, chin, nose or pectoral implants Collagen injections

5. Drugs to promote hair growth or loss

6. Facial bone reconstruction, reduction or sculpturing (including jaw shortening) and rhinoplasty

7. Hair transplantation

8. Lip reduction

10. Thyroid chondroplasty

Permanent Hair Removal

Genital electrolysis is not considered a surgical procedure, but is performed in conjunction with genital surgery (i.e., when required for vaginoplasty or phalloplasty).

Coverage is not available for any surgeries, services or procedures that are purely cosmetic (i.e., when performed solely to enhance appearance, but not to medically treat the underlying gender dysphoria). The following surgery, services and procedures will be reviewed on a case by case basis. It is expected that the clinical rationale for each requested procedure is specifically documented in the letter of medical necessity from the treating physician: ...

Voice Therapy And Surgery

Coverage is not available for any surgeries, services or procedures that are purely cosmetic (i.e., when performed solely to enhance appearance, but not to medically treat the underlying gender dysphoria). The following surgery, services and procedures will be reviewed on a case by case basis. It is expected that the clinical rationale for each requested procedure is specifically documented in the letter of medical necessity from the treating physician: ...

Youth Services

1. Treatment with gonadotropin-releasing hormone agents (pubertal suppressants) when based upon a determination by a qualified medical professional that the member is eligible and ready for such treatment, i.e., that the member: a. Meets gender dysphoria diagnostic criteria b. Has experienced puberty to at least Tanner stage 2 with pubertal changes resulting in increased gender dysphoria c. Does not suffer from psychiatric comorbidity that interferes with diagnostic work-up or treatment d. Has adequate psychological and social support during treatment e. Demonstrates knowledge and understanding of expected treatment-outcomes associated with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment

2. Treatment with cross-sex hormones for members ≥ 16 years of age when based upon a determination of medical necessity made by a qualified medical professional. (Members < 18 years of age must meet Criteria # 1).

Note: Requests for coverage of cross-sex hormones for members less than 16 years of age will be reviewed on a case-by-case basis.

Requests for gender reassignment surgery for members less than 18 years will be reviewed on a case-by-case basis.