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<th>Policy</th>
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<td>Gender dysphoria</td>
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<td>Policy Number</td>
<td>CCP.1358</td>
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<td>Policy Issued In</td>
<td>Florida</td>
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<td>Last Update</td>
<td>2018-03-01</td>
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<td>Breast Reconstruction</td>
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Candidate Criteria:

A. The member is an adult age 18 or older, or documented as an emancipated adolescent, or has documentation of appropriate consent from parent or guardian.

B. The member has the capacity to make fully informed decisions and consent for treatment.

C. The member has received a diagnosis of gender dysphoria by a qualified health professional.

The diagnosis must be based on:

1. Strong and persistent cross-gender identification. In adolescents and adults, the condition is manifested by symptoms such as a stated desire to be the other gender, frequent passing as the other gender, desire to live or be treated as the other gender, or the conviction that he or she has the typical feelings and reactors of the other gender.
2. Persistent discomfort (dysphoria) with his/her gender or sense of inappropriateness in the gender role of that sex.
3. The dysphoria is not concurrent with a physical intersex condition.
4. The dysphoria causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The member desires to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his/her body conform as much as possible to the preferred sex through surgery and hormone treatment.

E. The member has had real-life experience of at least 12 months in his/her desired gender.

F. Gender dysphoria is not a symptom of another mental disorder.

Referrals for Surgical Procedures

One or more referrals from a qualified mental health professional are necessary for certain procedures, including:

A. Breast/chest surgery, including mastectomy, chest reconstruction, and augmentation mammoplasty (one letter).

B. Genital surgery, including hysterectomy, salpingo-oophorectomy, orchiectomy, and genital reconstruction (two letters, one from the member’s psychotherapist, one from a professional who had an evaluative role).

Referral letters should include member identification, results of psychosocial assessments, duration of practitioner relationship with the member, a statement explaining that the criteria for surgery have been met, a statement that the member has given informed consent, and a statement that the practitioner is available for coordination of care.

Breast/Chest Surgery. Breast augmentation and mastectomy for female to male (transmen) and creation of male chest for male to female (transwomen) members are considered medically necessary when the following criteria are met:

1. Persistent gender dysphoria is well documented.
2. Member has the capacity to make informed decisions and consent to treatment.
3. Member is of majority (adults only).
4. Any significant medical or mental health concerns are controlled.
5. Member has had at least 12 months of feminizing hormone therapy (recommended for breast augmentation).
6. One letter of referral is submitted

Youth Services

Adolescents. Various hormones can be given to members not of majority age undergoing gender transformation. Similar to adults, the specific hormones vary by individual, but often serve to suppress puberty in the member’s birth gender. All cases must observe the following criteria:

1. The member has a long-lasting and intense pattern of gender nonconformity or dysphoria.
2. Gender dysphoria emerged or worsened with the onset of puberty.
3. Any co-existing psychological, social, or medical problems that could interfere with treatment have been addressed, and the member’s condition is stable.
4. The member has given informed consent, or (if not of age) parents, other caretakers, or guardians have consented to treatment and are involved in the treatment process.