# Contraception and Sterilization

**Policy Number**: BIP064.N
**Effective Date**: April 1, 2025

➲ Instructions for Use

**Table of Contents** **Page**



**Related Medical Policy**

- Preventive Care Services

## Federal/State Mandated Regulations

**Note:** The most current federal/state mandated regulations for each state can be found in the links below.

### California

### *California Health and Safety Code (HSC) Section 1367.25*

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.25.

(a) A group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, to December 31, 2015, inclusive, and an individual health care service plan contract that is amended, renewed, or delivered on or after January 1, 2000, to December 31, 2015, inclusive, except for a specialized health care service plan contract, shall provide coverage for the following, under general terms and conditions applicable to all benefits:
  (1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration (FDA)-approved prescription contraceptive methods designated by the plan. In the event the patient's participating provider, acting within the provider's scope of practice, determines that none of the methods designated by the plan is medically appropriate for the patient's medical or personal history, the plan shall also provide coverage for another FDA-approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.
  (2) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered non-spouse dependents.

(b) (1) A health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following services and contraceptive methods for all subscribers and enrollees:
    (A) (i) Except as provided in clause (ii) and in subparagraphs (B) and (C) of paragraph (2), all FDA-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.
      (ii) For any health care service plan contract described in paragraph (1) that is issued, amended, renewed, or delivered on or after January 1, 2024, both of the following conditions shall apply:
        (I) A prescription shall not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products.
        (II) Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products shall be provided at in-network pharmacies without cost sharing or medical management restrictions.
    (B) Voluntary tubal ligation and other similar sterilization procedures.
    (C) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.

(D) Followup services related to the drugs, devices, products, and procedures covered under this subdivision, including but not limited to management of side effects, counseling for continued adherence, and device removal.

(2) (A) Except for a grandfathered health plan, a health care service plan subject to this subdivision shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision. Cost sharing shall not be imposed on any Medi-Cal beneficiary.

(B) If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, a health care service plan is not required to cover all of those therapeutically equivalent versions in accordance with this subdivision, as long as at least one is covered without cost sharing in accordance with this subdivision. If there is no therapeutic equivalent generic substitute available in the market, a health care service plan shall provide coverage without cost sharing for the original, brand name contraceptive.

(C) If a covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the enrollee's provider, a health care service plan shall defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost-sharing requirements. Medical inadvisability may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives, and ability to adhere to the appropriate use of the drug or item, as determined by the provider. The department may promulgate regulations establishing an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome, including timeframes, for an enrollee, an enrollee's designee, or an enrollee's provider to request coverage of an alternative prescribed contraceptive. A request for coverage under this subparagraph that is submitted by an enrollee, an enrollee's designee, or provider shall be approved by the health care service plan in compliance with the time limits in Section 1367.241 and, as applicable, with the plan's Medi-Cal managed care contract.

(3) Except as otherwise authorized under this section, a health care service plan shall not infringe upon an enrollee's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required under this subdivision, including prior authorization, step therapy, or other utilization control techniques.

(4) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered non-spouse dependents.

(5) For purposes of this subdivision, "health care service plan" shall include Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that the benefits described in this subdivision are made the financial responsibility of the Medi-Cal managed care plan under its comprehensive risk contract with the State Department of Health Care Services. If some or all of the benefits described in this subdivision are not the financial responsibility of the Medi-Cal managed care plan, as determined by the State Department of Health Care Services, those benefits shall be available to Medi-Cal beneficiaries on a fee-for-service basis pursuant to subdivision (n) of Section 14132 of the Welfare and Institutions Code.

(c) (1) Notwithstanding any other provision of this section, a religious employer may request a health care service plan contract without coverage for FDA-approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods. The exclusion from coverage under this provision shall not apply to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.

(2) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization as described in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(d) (1) Every health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 2017, shall cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) This subdivision shall not be construed to require a health care service plan contract to cover contraceptives provided by an out-of-network provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as may be otherwise authorized by state or federal law or by the plan's policies governing out-of-network coverage.

(3) This subdivision shall not be construed to require a provider to prescribe, furnish, or dispense 12 months of self-administered hormonal contraceptives at one time.

(4) A health care service plan subject to this subdivision, shall not impose utilization controls or other forms of medical management limiting the supply of FDA-approved, self-administered hormonal contraceptives that may be dispensed or furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply, and shall not require an enrollee to make any formal request for such coverage other than a pharmacy claim.

(e) This section shall not be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within the provider's scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an enrollee.

(f) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for contraceptive drugs, devices, and products.

(g) This section shall not be construed to require an individual or group health care service plan contract to cover experimental or investigational treatments.

(h) For purposes of this section, the following definitions apply:
(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.
(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.
(3) With respect to health care service plan contracts issued, amended, or renewed on or after January 1, 2016, "provider" means an individual who is certified or licensed to furnish family planning services within their scope of practice pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, including a pharmacist authorized pursuant to Section 4052 or 4052.3 of the Business and Professions Code, or an initiative act referred to in that division, or Division 2.5 (commencing with Section 1797) of this code.
(4) For purposes of this section, "over-the-counter FDA-approved contraceptive drugs, devices, and products" and "over-the-counter birth control methods" are limited to those included as essential health benefits pursuant to Section 1367.005.

[Amended by Stats. 2022, Ch. 630, Sec. 13. (SB 523), effective January 1, 2023.]

## *HSC Section 1367.255*

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.255

(a) (1) A health care service plan contract issued, amended, renewed, or delivered on or after January 1, 2024, except for a grandfathered health plan or a qualifying health plan for a health savings account, shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on vasectomy services and procedures. For a qualifying health plan for a health savings account, the carrier shall establish the plan's cost sharing for vasectomy services and procedures at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account under Internal Revenue Service laws, regulations, and guidance. Cost sharing shall not be imposed on a Medi-Cal beneficiary.
(2) A health care service plan shall not impose any restrictions or delays, including but not limited to prior authorization, on vasectomy services or procedures.
(3) Benefits for an enrollee under this section shall be the same for an enrollee's covered spouse and covered non-spouse dependents.
(4) For purposes of this section, "health care service plan" includes Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that the benefits described in this subdivision are made the financial responsibility of the Medi-Cal managed care plan under its comprehensive risk contract with the State Department of Health Care Services. If some or all of the benefits described in this subdivision are not the financial responsibility of the Medi-Cal managed care plan, as determined by the State Department of Health Care Services, those benefits shall be available to Medi-Cal beneficiaries on a fee-for-service basis pursuant to subdivision (n) of Section 14132 of the Welfare and Institutions Code.
(5) Utilization controls applicable to services described in this section provided by a Medi-Cal managed care plan shall be subject to this section.

(b) Notwithstanding any other provision of this section, a religious employer may request a health care service plan contract without coverage for contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a health care service plan contract shall be provided without coverage for vasectomy services and procedures. The exclusion from coverage under this provision shall not apply to vasectomy services or procedures for purposes other than contraception.
(1) A health care service plan that contracts with a religious employer to provide a health care service plan that does not include coverage and benefits for vasectomy services and procedures shall notify, in writing, upon initial

enrollment and annually thereafter upon renewal, each enrollee that vasectomy services and procedures are not included in the enrollee's health care service plan.

(2) For purposes of this section, a "religious employer" is an entity for which each of the following is true:
(A) The inculcation of religious values is the purpose of the entity.
(B) The entity primarily employs persons who share the religious tenets of the entity.
(C) The entity serves primarily persons who share the religious tenets of the entity.
(D) The entity is a nonprofit organization as described in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(c) This section shall not be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for contraceptive drugs, devices, and products.

(d) This section shall not be construed to require an individual or group health care service plan contract to cover experimental or investigational treatments.

(e) For purposes of this section, the following definitions apply:
(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.
(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

[Added Stats 2022 ch 630 § 14 (SB 523), effective January 1, 2023.]

### *HSC Section 1367.32*

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.32

(a) A health care service plan that provides health coverage to the employees of a religious employer that does not include coverage and benefits for both abortion and contraception shall provide, in writing upon initial enrollment and annually thereafter upon renewal, each enrollee with information regarding both of the following:
(1) Abortion and contraception benefits or services that are not included in the enrollee's health care service plan contract.
(2) Abortion and contraception benefits or services that may be available at no cost through the California Reproductive Health Equity Program.

(b) For purposes of this section:
(1) "Abortion" has the same meaning as defined in Section 123464.
(2) "California Reproductive Health Equity Program" means the program established pursuant to Section 127632.
(3) "Contraception" means the services and contraceptive methods described in paragraph (1) of subdivision (b) of Section 1367.25. (4) "Religious employer" has the same meaning as described in Section 1367.25.
(4) "Religious employer" has the same meaning as described in Section 1367.25.

(c) This section does not alter the applicability of any other requirement of this chapter.

[Added Stats 2022 ch 562 § 1 (AB 2134), effective January 1, 2023.]

## State Market Plan Enhancements

Members may have a supplemental outpatient drug benefit for oral contraceptives. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) to determine coverage eligibility.

## Covered Benefits

**Important Note:** Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Some hospitals and other providers do not provide one or more of the following services that may be covered under the member's health plan contract and that the member or the member's family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. The member should obtain more information before they enroll. Call the member's prospective doctor, medical group, independent practice association, or clinic, or call UnitedHealthcare at 1-800-624-8822 or 711 (TTY) to ensure that the member can get the health care services that they need.

If the member has chosen a network medical group that does not provide the family planning benefits they need, and these benefits have been purchased by the member's employer group, call UnitedHealthcare.

For information related to those items covered under the Expanded Women's Preventive Health Mandate, refer to the Medical Policy titled Preventive Care Services.

The following benefits are available:

- Office visits for general education, counseling, instruction and follow up for birth control/contraception methods.
- Sterilization including vasectomy and tubal ligation [including follow-up (hysterosalpingogram) examinations] are covered in accordance with the FDA guidelines.
- Depo-Provera injections.
- Insertion and removal of FDA approved implantable contraceptive devices.
- Professional services related to insertion and removal of intrauterine device (IUD).
- Pregnancy testing.
- Cervical caps.
- Diaphragms.
- Oral contraceptives.
  **Notes:**
  - Members may have a supplemental outpatient drug benefit for oral contraceptives. Refer to the member's EOC/SOB to determine coverage eligibility.
  - Where FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, we are only required to cover at least one therapeutic equivalent without cost sharing subject to UnitedHealthcare's prior authorization process. If a contraceptive is prescribed for other than contraceptive purposes, the copay or coinsurance at the applicable prescription drug tier will apply.
  - If UnitedHealthcare's generic or no cost brand is determined medically inappropriate as determined by UnitedHealthcare's prior authorization process (e.g., the member has had previous side effects or failure), coverage will be provided for the non-preferred contraceptive at no cost to the member.
- All other FDA approved contraceptive drugs, devices, and products available over the counter as prescribed by the member's provider.

## Not Covered

- Hysterectomy for sterilization purposes
- Reversal of sterilization procedures

## Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 04/01/2025 | **Title Change**<br>• Previously titled *Family Planning: Contraception and Sterilization*<br>**Federal/State Mandated Regulations**<br>• Revised language pertaining to the *California Health and Safety Code Section 1367.32*<br>**Supporting Information**<br>• Archived previous policy version BIP064.M |

## Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.