Contraception and Sterilization

Policy Number: BIP065.Q
Effective Date: April 1, 2025

➲ Instructions for Use

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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

Oklahoma, Oregon, Texas, and Washington

Also refer to Affordable Care Act Implementation FAQs – Part 31, available at https://www.irs.gov/pub/irs-drop/n-18-12.pdf https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf

Oklahoma

Oklahoma Title 365:40-5-20 (10)(C), Basic Health Care Services

https://www.oid.ok.gov/wp-content/uploads/2019/10/091517_C40S5.pdf

Basic health care services shall include:

(10) Preventive health services, which shall be made available to enrollees and shall include at least the following:
  (C) Periodic health evaluations for adults to include voluntary family planning services.

Oregon

Oregon Revised Statutes (ORS) Section 743A.066, Contraceptives

ORS 743A.066 – Contraceptives (public.law)
https://www.oregonlegislature.gov/bills_laws/ors/ors743a.html

(1) A prescription drug benefit program, or a prescription drug benefit offered under a health benefit plan as defined in ORS 743B.005 (Definitions) or under a student health insurance policy, must provide payment, coverage or reimbursement for:
  (a) Prescription contraceptives; and
  (b) If covered for other drug benefits under the program, plan or policy, outpatient consultations, including pharmacist consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription contraceptive.

(2) The coverage required by subsection (1) of this section:
  (a) May be subject to provisions of the program, plan or policy that apply equally to other prescription drugs covered by the program, plan or policy, including but not limited to required copayments, deductibles and coinsurance; and
  (b) Must reimburse a health care provider or dispensing entity for a dispensing of contraceptives intended to last for a:
    (A) Three-month period for the first dispensing of the contraceptive to an insured; and
    (B) Twelve-month period for subsequent dispensings of the same contraceptive to the insured regardless of whether the insured was enrolled in the program, plan or policy at the time of the first dispensing.

(3) As used in this section, 'prescription contraceptive' means a drug or device that requires a prescription and is approved by the United States Food and Drug Administration to prevent pregnancy.

(4) A religious employer is exempt from the requirements of this section with respect to a prescription drug benefit program or a health benefit plan it provides to its employees. A 'religious employer' is an employer:
  (a) Whose purpose is the inculcation of religious values;
  (b) That primarily employs persons who share the religious tenets of the employer;
  (c) That primarily serves persons who share the religious tenets of the employer; and
  (d) That is a nonprofit organization under section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code.
(5) This section is exempt from the provisions of ORS 743A.001.

ORS Section 743A.067, Reproductive Health Services

https://www.oregonlaws.org/ors/743A.067

(1) As used in this section:
  (a) "Contraceptives" means health care services, drugs, devices, products or medical procedures to prevent a pregnancy.
(2) A health benefit plan offered in this state must provide coverage for all of the following services, drugs, devices, products and procedures:
  (j) Any contraceptive drug, device or product approved by the United States Food and Drug Administration, subject to all of the following:
    (A) If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the United States Food and Drug Administration, a health benefit plan may provide coverage for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.
    (B) If a contraceptive drug, device or product covered by the health benefit plan is deemed medically inadvisable by the enrollee's provider, the health benefit plan must cover an alternative contraceptive drug, device or product prescribed by the provider.
    (C) A health benefit plan must pay pharmacy claims for reimbursement of all contraceptive drugs available for over-the-counter sale that are approved by the United States Food and Drug Administration.
    (D) A health benefit plan may not infringe upon an enrollee's choice of contraceptive drug, device or product and may not require prior authorization, step therapy or other utilization control techniques for medically appropriate covered contraceptive drugs, devices or other products approved by the United States Food and Drug Administration.
  (k) Voluntary sterilization.
  (l) As a single claim or combined with other claims for covered services provided on the same day:
    (A) Patient education and counseling on contraception and sterilization.
    (B) Services related to sterilization or the administration and monitoring of contraceptive drugs, devices and products, including but not limited to:
      (i) Management of side effects;
      (ii) Counseling for continued adherence to a prescribed regimen;
      (iii) Device insertion and removal; and
      (iv) Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgment of the enrollee's provider.
  (m) Any additional preventive services for women that must be covered without cost sharing under 42 U.S.C. 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services as of January 1, 2017.

Texas

Texas Insurance Code (TIC) Section 1369 Subchapter C – Coverage of Prescription Contraceptive Drugs and Devices and Related Services

https://statutes.capitol.texas.gov/Docs/IN/htm/IN.1369.htm

Section 1369.101, Definitions

(2) "Outpatient contraceptive service" means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Section 1369.102, Applicability of Subchapter

Except as otherwise provided by this subchapter, this subchapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance

policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:
(1) An insurance company;
(2) A group hospital service corporation operating under Chapter 842;
(3) A fraternal benefit society operating under Chapter 885;
(4) A stipulated premium company operating under Chapter 884;
(5) A reciprocal exchange operating under Chapter 942;
(6) A health maintenance organization operating under Chapter 843;
(7) A multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or
(8) An approved nonprofit health corporation that holds a certificate of authority under Chapter 844.
[Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, effective April 1, 2005.]
[Amended by Acts 2023, 88th Leg., R.S., Ch. 395 (H.B. 916), Sec. 1, effective September 1, 2023.]

Section 1369.103, Exception

This subchapter does not apply to:
(1) A health benefit plan that provides coverage only:
  (A) For a specified disease or for another limited benefit otherthan for cancer;
  (B) For accidental death or dismemberment;
  (C) For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
  (D) As a supplement to a liability insurance policy;
  (E) For credit insurance;
  (F) For dental or vision care; or
  (G) For indemnity for hospital confinement;
(2) A Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;
(3) A workers' compensation insurance policy;
(4) Medical payment insurance coverage provided under a motor vehicle insurance policy; or
(5) A long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.102.
[Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, effective April 1, 2005.]

Section 1369.1031, Certain Coverage Required

(a) This section applies to a health benefit plan described by Section 1369.102.
(b) Notwithstanding any other law, this section applies to:
  (1) A standard health benefit plan issued under Chapter 1507;
  (2) A basic coverage plan under Chapter 1551;
  (3) A basic plan under Chapter 1575;
  (4) A primary care coverage plan under Chapter 1579;
  (5) A plan providing basic coverage under Chapter 1601;
  (6) Group health coverage made available by a school district in accordance with Section 22.004, Education Code; and
  (7) The state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code.
(c) A health benefit plan that provides benefits for a prescription contraceptive drug must provide for an enrollee to obtain up to:
  (1) A three-month supply of the covered prescription contraceptive drug at one time the first time the enrollee obtains the drug; and
  (2) A 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the enrollee obtains the same drug, regardless of whether the enrollee was enrolled in the health benefit plan the first time the enrollee obtained the drug.
(d) An enrollee may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.
[Added by Acts 2023, 88th Leg., R.S., Ch. 395 (H.B. 916), Sec. 2, effective September 1, 2023.]

Section 1369.104, Exclusion or Limitation Prohibited

(a) A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for:

(1) A prescription contraceptive drug or device approved by the United States Food and Drug Administration; or
(2) An outpatient contraceptive service.

(b) This section does not prohibit a limitation that applies to all prescription drugs or devices or all services for which benefits are provided under a health benefit plan.

(c) This section does not require a health benefit plan to cover abortifacients or any other drug or device that terminates a pregnancy.

Section 1369.105, Certain Cost-Sharing Provisions Prohibited

(a) A health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for prescription contraceptive drugs or devices unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for outpatient contraceptive services unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other outpatient services under the plan.

Section 1369.106, Certain Waiting Periods Prohibited

(a) A health benefit plan may not impose a waiting period applicable to benefits for prescription contraceptive drugs or devices unless the waiting period is the same as or shorter than any waiting period applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose a waiting period applicable to benefits for outpatient contraceptive services unless the waiting period is the same as or shorter than any waiting period applicable to benefits for other outpatient services under the plan.

Section 1369.107, Prohibited Conduct

A health benefit plan issuer may not:

(1) Solely because of the applicant's or enrollee's use or potential use of a prescription contraceptive drug or device or an outpatient contraceptive service, deny:
(A) The eligibility of an applicant to enroll in the plan;
(B) The continued eligibility of an enrollee for coverage under the plan; or
(C) The eligibility of an enrollee to renew coverage under the plan;

(2) Provide a monetary incentive to an applicant for enrollment or an enrollee to induce the applicant or enrollee to accept coverage that does not satisfy the requirements of this subchapter; or

(3) Reduce or limit a payment to a health care professional, or otherwise penalize the professional, because the professional prescribes a contraceptive drug or device or provides an outpatient contraceptive service.

Section 1369.108, Exemption for Entities Associated With Religious Organization

(a) This subchapter does not require a health benefit plan that is issued by an entity associated with a religious organization or any physician or health care provider providing medical or health care services under the plan to offer, recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing a medical or health care service that violates the religious convictions of the organization, unless the prescription contraceptive coverage is necessary to preserve the life or health of the enrollee.

(b) An issuer of a health benefit plan that excludes or limits coverage for medical or health care services under this section shall state the exclusion or limitation in:
(1) The plan's coverage document;
(2) The plan's statement of benefits;
(3) Plan brochures; and
(4) Other informational materials for the plan.

Washington

Washington Administrative Code (WAC) Section 284-43-5150, Unfair Practice Relating to Health Coverage

https://apps.leg.wa.gov/wac/default.aspx?cite=284-43-5150

(1) It is an unfair practice for any health carrier to restrict, exclude, or reduce coverage or benefits under any health plan on the basis of sex. By way of example, a health plan providing generally comprehensive coverage of prescription

drugs and prescription devices restricts, excludes, or reduces coverage or benefits on the basis of sex if it fails to provide prescription contraceptive coverage that complies with this regulation.
An example of a plan that provides generally comprehensive coverage of prescription drugs is a plan that covers prescription drugs but excludes some categories such as weight reduction or smoking cessation.

(2) (a) Health plans providing generally comprehensive coverage of prescription drugs and/or prescription devices shall not exclude prescription contraceptives or cover prescription contraceptives on a less favorable basis than other covered prescription drugs and prescription devices. Coverage of prescription contraceptives includes coverage for medical services associated with the prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services.
(b) Health plans may not impose benefit waiting periods, limitations, or restrictions on prescription contraceptives that are not required or imposed on other covered prescription drugs and prescription devices.
(c) Health plans may not require cost sharing, such as copayments or deductibles, for prescription contraceptives and for services associated with the prescribing, dispensing, delivery, distribution, administration, and removal of the prescription contraceptives.
(d) Health carriers may use, and health plans may limit coverage to, a closed formulary for prescription contraceptives if they otherwise use a closed formulary, but the formulary shall cover each of the types of prescription contraception as defined in (e) of this subsection.
(e) For purposes of subsections (1) and (2) of this section, "prescription contraceptives" include United States Food and Drug Administration (FDA) approved contraceptive drugs, devices, and prescription barrier methods, including contraceptive products declared safe and effective for use as emergency contraception by the FDA.

Revised Code of Washington (RCW) Section 48.43.195, Contraceptive Drugs—Twelve-Month Refill Coverage

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.195

(1) A health benefit plan issued or renewed on or after January 1, 2018, that includes coverage for contraceptive drugs must provide reimbursement for a twelve-month refill of contraceptive drugs obtained at one time by the enrollee, unless the enrollee requests a smaller supply or the prescribing provider instructs that the enrollee must receive a smaller supply. The health plan must allow enrollees to receive the contraceptive drugs on-site at the provider's office, if available. Any dispensing practices required by the plan must follow clinical guidelines for appropriate prescribing and dispensing to ensure the health of the patient while maximizing access to effective contraceptive drugs.
(2) Nothing in this section prohibits a health plan from limiting refills that may be obtained in the last quarter of the plan year if a twelve-month supply of the contraceptive drug has already been dispensed during the plan year.
(3) For purposes of this section, "contraceptive drugs" means all drugs approved by the United States food and drug administration that are used to prevent pregnancy, including but not limited to hormonal drugs administered orally, transdermally, and intravaginally.

RCW Section 48.43.072, Required Reproductive Health Care Coverage—Restrictions on Copayments, Deductibles, and Other Form of Cost Sharing

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.072

(1) A health plan or student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, shall provide coverage for:
(a) All contraceptive drugs, devices, and other products, approved by the federal food and drug administration, including over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration. This includes condoms, regardless of the gender or sexual orientation of the covered person, and regardless of whether they are to be used for contraception or exclusively for the prevention of sexually transmitted infections;
(b) Voluntary sterilization procedures;
(c) The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services in (a) and (b) of this subsection;
(d) The following preventive services:
(i) Screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault; and
(ii) Well-person preventive visits;
(e) Medically necessary services and prescription medications for the treatment of physical, mental, sexual, and reproductive health care needs that arise from a sexual assault; and

(f) The following reproductive health-related over-the-counter drugs and products approved by the federal food and drug administration: Prenatal vitamins for pregnant persons; and breast pumps for covered persons expecting the birth or adoption of a child.

(2) The coverage required by subsection (1) of this section:
  (a) May not require copayments, deductibles, or other forms of cost sharing:
    (i) Except for:
      (A) The medically necessary services and prescription medications required by subsection (1)(e) of this section; and
      (B) The drugs and products in subsection (1)(f) of this section; or
    (ii) Unless the health plan is offered as a qualifying health plan for a health savings account. For such a qualifying health plan, the carrier must establish the plan's cost sharing for the coverage required by subsection (1) of this section 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 and regulations; and
  (b) May not require a prescription to trigger coverage of over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration, except those reproductive health-related drugs and products as set forth in subsection (1)(f) of this section.

(3) A health carrier may not deny the coverage required in subsection (1) of this section because an enrollee changed the enrollee's contraceptive method within a twelve-month period.

(4) Except as otherwise authorized under this section, a health benefit plan may not impose any restrictions or delays on the coverage required under this section, such as medical management techniques that limit enrollee choice in accessing the full range of contraceptive drugs, devices, or other products, approved by the federal food and drug administration.

(5) Benefits provided under this section must be extended to all enrollees, enrolled spouses, and enrolled dependents.

(6) This section may not be construed to allow for denial of care on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability.

(7) A health plan or student health plan, including student health plans deemed by the insurance commissioner to have a short-term limited purpose or duration or to be guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, issued or renewed on or after January 1, 2021, may not issue automatic initial denials of coverage for reproductive health care services that are ordinarily or exclusively available to individuals of one gender, based on the fact that the individual's gender assigned at birth, gender identity, or gender otherwise recorded in one or more government-issued documents, is different from the one to which such health services are ordinarily or exclusively available.

(8) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.
  (a) "Gender expression" means a person's gender-related appearance and behavior, whether or not stereotypically associated with the person's gender assigned at birth.
  (b) "Gender identity" means a person's internal sense of the person's own gender, regardless of the person's gender assigned at birth.
  (c) "Reproductive health care services" means any medical services or treatments, including pharmaceutical and preventive care service or treatments, directly involved in the reproductive system and its processes, functions, and organs involved in reproduction, in all stages of life. Reproductive health care services does not include infertility treatment.
  (d) "Reproductive system" includes but is not limited to: Genitals, gonads, the uterus, ovaries, fallopian tubes, and breasts.
  (e) "Well-person preventive visits" means the preventive annual visits recommended by the federal health resources and services administration women's preventive services guidelines, with the understanding that those visits must be covered for women, and when medically appropriate, for transgender, nonbinary, and intersex individuals.

(9) This section may not be construed to authorize discrimination on the basis of gender identity or expression, or perceived gender identity or expression, in the provision of nonreproductive health care services.

(10) The commissioner, under RCW 48.30.300, and the human rights commission, under chapter 49.60 RCW[,] shall share enforcement authority over complaints of discrimination under this section as set forth in RCW 49.60.178.

(11) The commissioner may adopt rules to implement this section.

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, tubal ligation [including tubal ligation 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 (refer to note above).

Not Covered

- Hysterectomy for sterilization purposes
- Reversal of sterilization procedures

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
04/01/2025	All	**Title Change** • Previously titled *Family Planning: Contraception and Sterilization* **Supporting Information** • Archived previous policy version BIP065.P

	Texas	**Federal/State Mandated Regulations**
		• Added language pertaining to the *Texas Insurance Code*:
		  ○ *Section 1369.102*
		  ○ *Section 1369.103*
		  ○ *Section 1369.1031*

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.