

Family Planning: Birth Control

Policy Number: BIP064.K
Effective Date: May 1, 2022

[➔ Instructions for Use](#)

Table of Contents	Page
Federal/State Mandated Regulations	1
State Market Plan Enhancements	3
Covered Benefits	3
Not Covered	4
Policy History/Revision Information	4
Instructions for Use	4

Related Medical Management Guideline
<ul style="list-style-type: none"> 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 Health & Safety Code 1367.25.

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

- (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, through December 31, 2015, inclusive, and an individual health care service plan contract that is amended, renewed, or delivered on or after January 1, 2000, through 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 his or her 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 women:
- (A) Except as provided in subparagraphs (B) and (C) of paragraph (2), all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee’s provider.
 - (B) Voluntary sterilization procedures.
 - (C) Patient education and counseling on contraception.
 - (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 insertion and 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 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.
- (C) If a covered therapeutic equivalent of a drug, device, or product is not available, or is deemed medically inadvisable by the enrollee's provider, a health care service plan shall provide coverage, subject to a plan's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost sharing. Any request by a contracting provider shall be responded to by the health care service plan in compliance with the Knox-Keene Health Care Service Plan Act of 1975, as set forth in this chapter 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 impose any restrictions or delays on the coverage required under this subdivision.
- (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 paragraphs (2) and (3) of this subdivision, and subdivision (d) "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.
- (c) 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.
 - (1) 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.
 - (2) Every religious employer that invokes the exemption provided under this section shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.
- (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) Nothing in this subdivision shall 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) Nothing in this subdivision shall 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, in the absence of clinical contraindications, 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.
- (e) This section shall not be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within his or her 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 pursuant to Division 2 (commencing with Section 500) 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.

State Market Plan Enhancements

None

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.

Note:

- Some hospitals and other Providers do not provide one or more of the following services that may be covered under your Health Plan contract and that you or your 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. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Customer Service department at 1-800-624-8822 or 711 (TTY) to ensure that you can get the health care services that you need.
- If you have chosen a Network Medical Group that does not provide the family planning benefits you need, and these benefits have been purchased by your Employer Group, call our Customer Service department.

For information related to those items covered on or after 08/01/2012 under the Expanded Women’s Preventive Health Mandate, refer to the Medical Management Guideline titled [Preventive Care Services](#).

Note for Bolded Items Below: Information related to those items covered on or after 08/01/2012 under the Expanded Women’s Preventive Health Mandate, refer to the Medical Management Guideline titled [Preventive Care Services](#).

- Office visits for general education, counseling, instruction and follow up for birth control/ contraception methods (see note above)
- Sterilization
 - Vasectomy
 - Tubal ligation [Note: This includes the tubal occlusive procedure, i.e., Essure. Tubal Ligation follow-up (hysterosalpingogram) examinations will be covered in accordance with the FDA guidelines. FDA information available at <http://www.fda.gov/default.htm>] (See Note above.)
- Depo-Provera injections (see note above)
- Removal of FDA approved Implantable Contraceptive Devices (i.e., Implanon) (see note above)
- Professional services related to insertion and removal of Intrauterine device (IUD) (see note above)
- Pregnancy testing (see note above)
- Cervical Caps (see note above)
- Diaphragms (see note above)
- Oral Contraceptives (see note above)
- All other FDA approved contraceptive drugs, devices, and products available over the counter as prescribed by the member’s provider (see note above)

Notes:

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.

Not Covered

- Hysterectomy for sterilization purposes
- Reversal of sterilization procedures

Policy History/Revision Information

Date	Summary of Changes
05/01/2022	<ul style="list-style-type: none">• Routine review; no change to coverage guidelines• Archived previous policy version BIP064.J

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.