DEPARTMENT OF Managed Health Care

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.DMHC.ca.gov

ALL PLAN LETTER

DATE: December 30, 2025

TO: All Full-Service Health Plans[1]

FROM: Sarah Ream
Chief Counsel

SUBJECT: APL 25-021 - Implementation of Senate Bill 729 (2024)

I. Background

Senate Bill 729 (Menjivar, 2024) amended Health and Safety Code section 1374.55[2] of the Knox-Keene Act. SB 729 as enacted required large group health contracts issued, amended, or renewed on or after July 1, 2025, to *cover* the diagnosis and treatment of infertility and fertility services.[3] Likewise, SB 729 as enacted, required small group health plan contracts issued, amended, or renewed on or after July 1, 2025 to *offer* coverage for the diagnosis and treatment of infertility and fertility services.

However, Assembly Bill 116 (Committee on Budget, 2025) delayed the effective date from July 1, 2025, to January 1, 2026. AB 116 also specified that the Department of Managed Health Care (DMHC) may issue guidance regarding compliance with section 1374.55 and such guidance shall not be subject to the Administrative Procedure Act. Per that authority, the DMHC issues the following guidance to health plans.

II. Definitions

For purposes of section 1374.55 and this All Plan Letter (APL), the following definitions apply:

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[1] The APL applies to all full-service commercial plans. It does not apply to Medi-Cal managed care plans or to Medicare Advantage plans. The APL does not apply to religious employers, as defined in Health and Safety Code section 1367.25.
[2] All statutory references in this APL refer to sections in the California Health and Safety Code unless otherwise specified.
[3] SB 729/AB 116 does not apply to health plan contracts entered into with the Board of Administration of the Public Employees' Retirement System until July 1, 2027. After that date, the requirements in Health and Safety Code section 1374.55 and this APL apply to such contracts.

1. “Donor” means an individual from whom eggs, sperm, or embryos are obtained through means other than through sexual intercourse.

2. “Surrogate” means a person who bears and carries a child for another through medically assisted reproduction and pursuant to a written agreement, as set forth in Family Code Sections 7606 and 7962

III. Covered treatments for infertility and fertility services

A large group health care service plan contract subject to section 1374.55 shall cover and a small group health plan contract subject to section 1374.55 shall offer to cover the diagnosis and treatment of infertility and medically necessary fertility services consistent with established medical practices and the most current professional guidelines for the diagnosis and treatment of infertility as published by the American Society for Reproductive Medicine (ASRM).[4] Any medical necessity determination or the utilization review criteria applied by the health plan or any entity acting on the health plan’s behalf to determine the medical necessity of infertility services must be consistent with established medical practices and the most current professional guidelines as established by ASRM.

1. Services to diagnose infertility as follows:

    a. Physician services, including consultation and referral

    b. Physical examination

    c. Genetic evaluation

    d. Screening and diagnostic laboratory and imaging services

    e. Semen analysis

    f. Tubal evaluation and uterine evaluation

    g. Sperm DNA fragmentation analysis

    h. Hormone testing

    i. Ovulation testing

    j. Thyroid function testing

    k. Ovarian reserve testing

[4] Small group plans must offer coverage for the diagnosis and treatment of infertility in accordance with this APL. However, small group plans are not subject to the retrieval coverage requirements (section III.2.a-b, section III.3.e.) and minimum storage periods (section III.4.) outlined in this APL.

l. Diagnostic surgery and biopsy

m. Any other services to diagnose infertility consistent with the established medical practices and the most current professional guidelines published by ASRM

2. Fertility services to treat infertility as follows:

   a. A maximum of three attempts to collect or retrieve sperm[5]

   b. A maximum of three completed oocyte retrievals[4]

   c. Procurement of donor semen, oocyte and embryo

   d. Physician services, including consultation and referral.

   e. Surgery to treat infertility

   f. Medication to treat infertility

   g. Reproductive counseling

   h. Genetic counseling

   i. Genetic testing and screening

   j. Laboratory and imaging services

   k. Infectious disease screening and testing

   l. Medication to induce ovulation

   m. Intrauterine insemination

   n. Intracervical insemination

   o. Preimplantation genetic testing

   p. In vitro maturation

   q. In vitro fertilization

   r. Intracytoplasmic sperm injection

   s. Ovarian tissue reimplantation

[5] The number of attempts to collect or retrieve sperm and the number of oocyte retrievals must not be limited, restricted, or reduced by the large group health plan contract to fewer than three attempts or retrievals.

t. Embryo biopsy

u. Assisted hatching

v. Thawing of previously cryopreserved gametes, embryos, and tissues

w. Unlimited embryo transfers, using single embryo transfers in accordance with section 1374.55(a)(1)

x. Any other fertility services to treat infertility consistent with the established medical practices and the most current professional guidelines published by ASRM

3. Donors, Donor Material, and Surrogate services as follows:

   a. Laboratory and imaging services

   b. Genetic testing and screening

   c. Infectious disease screening and testing

   d. Medication to induce ovulation

   e. Retrieval of donor gametes subject to the limitations specified in section III.2.a-b above.

   f. Gamete and embryo transfer

   g. Any other medically necessary infertility and fertility services, as specified in section III.2 above, to enable the enrollee to become a parent using donor gametes, donor embryos, and surrogate services

4. Cryopreservation and storage of sperm, oocytes, and embryos for a period of five years from the time the genetic material is first cryopreserved.

The requirements in Health and Safety Code section 1374.55, as amended by AB 116, and this APL do not require health plans to cover services that are not medically necessary, experimental, or investigational, unless otherwise required under existing law.

Pursuant to Health and Safety Code section 1374.55, health plans must provide coverage for the treatment of infertility without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

IV. Cryopreservation

With respect to cryopreservation of sperm, oocytes, and embryos, a health plan may select a storage vendor of its choice so long as the vendor holds a valid license issued by the California Department of Public Health to operate a tissue bank and the stored material remains in California. A plan has no obligation to continue to cover storage of genetic material for an individual who is no longer enrolled with the plan.

If an enrollee changes health plans during the covered storage period and the new plan deems it necessary to transport the sperm, oocytes, or embryos to a different storage facility, the enrollee’s new health plan shall be responsible for transportation costs of genetic material to the new health plan’s storage facilities. The new plan shall cover storage for the remainder of the applicable storage time frame. With respect to embryo cryopreservation, the transportation and storage costs must be paid by the new health plan providing coverage to the enrollee that received or is receiving infertility treatment.

The health plan covering the enrollee prior to the enrollee’s change in health plan coverage and the enrollee’s new health plan shall coordinate on the transfer and transportation of the cryopreserved sperm, oocytes, or embryos. The enrollee’s prior health plan shall provide the enrollee’s new health plan with information showing the beginning date of cryopreservation of the genetic material.

The enrollee’s new plan shall provide written notice to the enrollee that the new plan shall cover transportation and storage costs for the remainder of the applicable storage time or until the enrollee is no longer enrolled with the plan, whichever is shorter.

V. Prohibited denials of coverage

A plan shall not deny coverage for medically necessary treatments of infertility or fertility services based solely upon an enrollee’s prior diagnosis of infertility or an enrollee’s prior elective sterilization. However, a plan is not required to provide coverage for the surgical reversal of the elective sterilization.

The requirements in Health and Safety Code section 1374.55 and this APL do not abrogate or diminish a health plans’ obligation to provide basic health care services and prescription drugs as required by the Knox-Keene Act and its implementing regulations.

VI. Enrollee notices

No more than 30 business days after receipt of a claim for cryopreservation services, the health plan must provide the enrollee with written notice explaining the covered storage period. At a minimum, the notice must inform the enrollee of the following:

1. The covered storage period

2. Options for continued storage of genetic material if coverage ends prior to the expiration of the storage period

3. Any potential out-of-pocket costs to the enrollee associated with the continued storage of genetic material if coverage ends prior to the expiration of the storage period

At least 90 calendar days before the expiration of the storage periods described above, the plan shall provide the enrollee with written notice explaining the termination of the storage period. At a minimum, the notice must inform the enrollee of the following:

1. Options for continued storage of genetic material

2. Any potential out-of-pocket costs to the enrollee associated with the continued storage of genetic material after coverage has ended

A plan's Evidence of Coverage, Disclosure Forms, and any combined Evidence of Coverage and Disclosure Form must include the following statements separately in bold typeface and in no less than 12-point font:

> You have a right to receive treatment for infertility and fertility services when you meet the requirements in Health and Safety Code section 1374.55.
>
> If you have questions about how to obtain infertility treatment services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining infertility treatment services.

VII. Surrogacy

If an enrollee is using the services of a surrogate to treat the infertility of the enrollee, in addition to coverage of the above-described services, the enrollee's health plan shall cover medically necessary health testing of the surrogate, as necessary, for each attempt collect eggs or sperm or to create embryos, and for each attempt to achieve a pregnancy with that material.

The enrollee's health plan shall not be responsible for health care costs of the surrogate after the embryo transfer procedure, including maternity services, except as required under the terms of the surrogate's health plan contract.

VIII. Fertility preservation services

Health and Safety Code section 1374.551 and California Code of Regulations (CCR), title 28, section 1300.74.551 require health plans in the individual, small group, and large group commercial markets to cover "standard fertility preservation services," as defined in those sections, to treat iatrogenic infertility. The requirements in Health and

Safety Code section 1374.55 and this APL do not abrogate or impact health plans' obligations to cover standard fertility preservation services for iatrogenic infertility as required by the Knox-Keene Act and its implementing regulations. Likewise, the requirements of Health and Safety Code section 1374.551 and CCR section 1300.74.551, do not abrogate or otherwise reduce or limit health plans' obligations to cover diagnosis and treatment of infertility and fertility services as required by Health and Safety Code section 1374.55, this APL, and any other SB 729 implementing guidance or implementing regulations.

If an enrollee meets the requirements in Health and Safety Code section 1374.551 and CCR section 1300.74.551 regarding health plan coverage for fertility preservation services, the health plan must cover standard fertility preservation services subject to the retrieval, cryopreservation, and storage limitations outlined in CCR section 1300.74.551. If the same enrollee meets the requirements in Health and Safety Code section 1374.55 and this APL, the health plan must also cover fertility services to treat infertility subject to the retrieval, cryopreservation and storage limitations outlined in this APL. Retrieval, cryopreservation, and storage limitations in one statute and its implementing regulations or guidance must not be used to deny, restrict or limit the health plans' obligation to cover services pursuant to the other statute and its implementing regulations or guidance. For example, if an enrollee meets the requirements of both statues, the health plan subject to the requirements of these statutes and their respective implementing regulations and guidance would have to cover two attempts to collect sperm for fertility preservation purposes and three attempts to collect or retrieve sperm to treat infertility.

VIII. Large Group Rates

Health plans in the large group market already submitted rate filings for rates effective January 1, 2026. If a health plan intends to implement a change in methodology, factors, or assumptions for the large group market based on the requirements of SB 729 or this APL, the health plan shall submit a filing through the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF), no later than 120 days before implementing the rate change.

The Large Group Workbook and guidance can be found on the DMHC website.

Likewise, per Health and Safety Code section 1374.21(a)(2), a plan may not change the premium rate for a large group contract unless the plan has delivered to the contract holder a written notice indicating the change at least 120 days before the contract renewal effective date.

IX. Filing with the DMHC

On December 19, 2025, the DMHC issued APL 25-020 (OPL)—Newly Enacted Statutes Impacting Health Plans (2025 Legislative Session). That APL informed plans of pertinent newly-enacted legislation and directed plans to submit a compliance filing to the DMHC by March 19, 2026. The plans' compliance filings are to be titled "Compliance with 2025 Legislation."

APL 25-020 did not include SB 729. However, plans may need to amend their EOCs, Disclosure Forms, and other documents to ensure consistency with the requirements of SB 729 and this APL. **To demonstrate compliance with SB 729 and this APL, the DMHC directs health plans to include in their Compliance with 2025 Legislation filings the following information regarding SB 729 and this APL**:

State either:

- The plan reviewed its policies and procedures, EOCs, Disclosure Forms, and any other applicable documents and those documents are consistent with the requirements of SB 729 and APL 25-021.

  OR

- The plan reviewed its policies and procedures, EOCs, Disclosure Forms, and any other applicable documents and those documents are not consistent with the requirements of SB 729 and APL 25-021. The plan will amend these documents to comply with SB 729 and APL 25-021 and file the documents per the Knox-Keene Act's applicable timeframes.

If you have questions regarding this APL, please contact your health plan's assigned reviewer in the DMHC's Office of Plan Licensing.