General Assembly

Amendment

February Session, 2018

LCO No. **4243**

* H B 0 5 2 1 0 0 4 2 4 3 H D O *

Offered by:

REP. SCANLON, 98th Dist.
REP. PORTER, 94th Dist.
REP. CONLEY, 40th Dist.
REP. LINEHAN, 103rd Dist.
REP. SIMMONS, 144th Dist.
REP. MCCARTHY VAHEY, 133rd Dist.
SEN. FLEXER, 29th Dist.
REP. JULESON-SCOPINO, 12th Dist.

To: Subst. House Bill No. **5210** File No. 146 Cal. No. 117

"AN ACT MANDATING INSURANCE COVERAGE OF ESSENTIAL HEALTH BENEFITS AND EXPANDING MANDATED HEALTH BENEFITS FOR WOMEN, CHILDREN AND ADOLESCENTS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective January 1, 2019*) (a) For the purposes of this section, "essential health benefits" means health care services and benefits that fall within the following categories:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn health care;

(5) Mental health and substance use disorder services, including, but not limited to, behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including, but not limited to, oral and vision care.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2019, shall provide coverage for essential health benefits.

(c) No provision of the general statutes concerning a requirement of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, shall be construed to supersede any provision of this section that provides greater protection to an insured, except to the extent this section prevents the application of a requirement of the Affordable Care Act.

(d) The Insurance Commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the purposes of this section, including, but not limited to, regulations specifying the health care services and benefits that fall within each category set forth in subsection (a) of this section.

Sec. 2. (NEW) (*Effective January 1, 2019*) (a) For the purposes of this section:

(1) "Employee" has the same meaning as specified in section 38a-564 of the general statutes.

(2) "Essential health benefits" means health care services and benefits that fall within the following categories:

(A) Ambulatory patient services;

(B) Emergency services;

(C) Hospitalization;

(D) Maternity and newborn health care;

(E) Mental health and substance use disorder services, including, but not limited to, behavioral health treatment;

(F) Prescription drugs;

(G) Rehabilitative and habilitative services and devices;

(H) Laboratory services;

(I) Preventive and wellness services and chronic disease management; and

(J) Pediatric services, including, but not limited to, oral and vision care.

(3) (A) "Small employer" means an employer that employed an average of at least one but not more than fifty employees on business days during the preceding calendar year and employs at least one employee on the first day of the group health insurance policy year. "Small employer" does not include a sole proprietorship that employs only the sole proprietor or the spouse of such sole proprietor.

(B) (i) For the purposes of subparagraph (A) of this subdivision, the number of employees shall be determined by adding (I) the number of full-time employees for each month who work a normal work week of

thirty hours or more, and (II) the number of full-time equivalent employees, calculated for each month by dividing by one hundred twenty the aggregate number of hours worked for such month by employees who work a normal work week of less than thirty hours, and averaging such total for the calendar year.

(ii) If an employer was not in existence throughout the preceding calendar year, the number of employees shall be based on the average number of employees that such employer reasonably expects to employ in the current calendar year.

(b) Each group health insurance policy providing, through a small employer, coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, amended, renewed or continued in this state on or after January 1, 2019, shall provide coverage for essential health benefits.

(c) No provision of the general statutes concerning a requirement of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, shall be construed to supersede any provision of this section that provides greater protection to an insured, except to the extent this section prevents the application of a requirement of the Affordable Care Act.

(d) The Insurance Commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to carry out the purposes of this section, including, but not limited to, regulations specifying the health care services and benefits that fall within each category set forth in subdivision (2) of subsection (a) of this section.

Sec. 3. (NEW) (*Effective January 1, 2019*) (a) (1) Except as provided in subdivision (2) of this subsection, each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the following benefits and services:

(A) Domestic and interpersonal violence screening and counseling for any woman;

(B) Tobacco use intervention and cessation counseling for any woman who consumes tobacco;

(C) Well-woman visits for any woman who is younger than sixty-five years of age;

(D) Breast cancer chemoprevention counseling for any woman who is at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by such woman's physician or advanced practice registered nurse;

(E) Breast cancer risk assessment, genetic testing and counseling;

(F) Chlamydia infection screening for any sexually-active woman;

(G) Cervical and vaginal cancer screening for any sexually-active woman;

(H) Gonorrhea screening for any sexually-active woman;

(I) Human immunodeficiency virus screening for any sexually-active woman;

(J) Human papillomavirus screening for any woman with normal cytology results who is thirty years of age or older;

(K) Sexually transmitted infections counseling for any sexually-active woman;

(L) Anemia screening for any pregnant woman and any woman who is likely to become pregnant;

(M) Folic acid supplements for any pregnant woman and any woman who is likely to become pregnant;

(N) Hepatitis B screening for any pregnant woman;

(O) Rhesus incompatibility screening for any pregnant woman and follow-up rhesus incompatibility testing for any pregnant woman who is at increased risk for rhesus incompatibility;

(P) Syphilis screening for any pregnant woman and any woman who is at increased risk for syphilis;

(Q) Urinary tract and other infection screening for any pregnant woman;

(R) Breastfeeding support and counseling for any pregnant or breastfeeding woman;

(S) Breastfeeding supplies, including, but not limited to, a breast pump for any breastfeeding woman;

(T) Gestational diabetes screening for any woman who is twenty-four to twenty-eight weeks pregnant and any woman who is at increased risk for gestational diabetes;

(U) Osteoporosis screening for any woman who is sixty years of age or older;

(V) Such additional evidence-based items or services not described in subparagraphs (A) to (U), inclusive, of this subdivision that receive a rating of "A" or "B" in any recommendations of the United States Preventive Services Task Force effective after January 1, 2018; and

(W) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the United States Health Resources and Services Administration, as effective on January 1, 2018, and such additional preventive care and screenings provided for in any comprehensive guidelines supported by said administration and effective after January 1, 2018.

(2) No policy described in subdivision (1) of this subsection shall be required to provide coverage for any benefit or service described in subparagraphs (A) to (U), inclusive, of said subdivision unless such benefit or service is an evidence-based item or service that had a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force as such recommendations were in effect on January 1, 2018.

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a health savings account, as that term is used in Section 223 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 223. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 4. (NEW) (*Effective January 1, 2019*) (a) (1) Except as provided in subdivision (2) of this subsection, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the following benefits and services:

(A) Domestic and interpersonal violence screening and counseling for any woman;

(B) Tobacco use intervention and cessation counseling for any woman who consumes tobacco;

(C) Well-woman visits for any woman who is younger than sixty-five years of age;

(D) Breast cancer chemoprevention counseling for any woman who is at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by such woman's physician or advanced practice registered nurse;

(E) Breast cancer risk assessment, genetic testing and counseling;

(F) Chlamydia infection screening for any sexually-active woman;

(G) Cervical and vaginal cancer screening for any sexually-active woman;

(H) Gonorrhea screening for any sexually-active woman;

(I) Human immunodeficiency virus screening for any sexually-active woman;

(J) Human papillomavirus screening for any woman with normal cytology results who is thirty years of age or older;

(K) Sexually transmitted infections counseling for any sexually-active woman;

(L) Anemia screening for any pregnant woman and any woman who is likely to become pregnant;

(M) Folic acid supplements for any pregnant woman and any woman who is likely to become pregnant;

(N) Hepatitis B screening for any pregnant woman;

(O) Rhesus incompatibility screening for any pregnant woman and

follow-up rhesus incompatibility testing for any pregnant woman who is at increased risk for rhesus incompatibility;

(P) Syphilis screening for any pregnant woman and any woman who is at increased risk for syphilis;

(Q) Urinary tract and other infection screening for any pregnant woman;

(R) Breastfeeding support and counseling for any pregnant or breastfeeding woman;

(S) Breastfeeding supplies, including, but not limited to, a breast pump for any breastfeeding woman;

(T) Gestational diabetes screening for any woman who is twenty-four to twenty-eight weeks pregnant and any woman who is at increased risk for gestational diabetes;

(U) Osteoporosis screening for any woman who is sixty years of age or older;

(V) Such additional evidence-based items or services not described in subparagraphs (A) to (U), inclusive, of this subdivision that receive a rating of "A" or "B" in any recommendations of the United States Preventive Services Task Force effective after January 1, 2018; and

(W) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the United States Health Resources and Services Administration, as effective on January 1, 2018, and such additional preventive care and screenings provided for in any comprehensive guidelines supported by said administration and effective after January 1, 2018.

(2) No policy described in subdivision (1) of this subsection shall be required to provide coverage for any benefit or service described in subparagraphs (A) to (U), inclusive, of said subdivision unless such

benefit or service is an evidence-based item or service that had a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force as such recommendations were in effect on January 1, 2018.

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a health savings account, as that term is used in Section 223 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 223. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 5. (NEW) (*Effective January 1, 2019*) (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs shall provide coverage for (1) immunizations recommended by the American Academy of Pediatrics, American Academy of Family Physicians and the American College of Obstetricians and Gynecologists, and (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a health savings account, as that term is used in Section 223 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 223. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 6. (NEW) (*Effective January 1, 2019*) (a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs shall provide coverage for (1) immunizations recommended by the American Academy of Pediatrics, American Academy of Family Physicians and the American College of Obstetricians and Gynecologists, and (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection. The provisions of this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493 of the general

statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a health savings account, as that term is used in Section 223 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 223. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 7. (NEW) (*Effective January 1, 2019*) (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for preventive care and screenings for individuals twenty-one years of age or younger in accordance with the most recent edition of the American Academy of Pediatrics' "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents" or any subsequent corresponding publication.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a health savings account, as that term is used in Section 223 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section

223. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 8. (NEW) (*Effective January 1, 2019*) (a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for preventive care and screenings for individuals twenty-one years of age or younger in accordance with the most recent edition of the American Academy of Pediatrics' "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents" or any subsequent corresponding publication.

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under subsection (a) of this section. The provisions of this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493 of the general statutes, to the maximum extent permitted by federal law, except if such plan is used to establish a health savings account, as that term is used in Section 223 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 223. Nothing in this section shall preclude a policy that provides the coverage required under subsection (a) of this section and uses a provider network from imposing cost-sharing requirements for any benefit or service required under said subsection (a) that is delivered by an out-of-network provider.

Sec. 9. Subsection (a) of section 38a-482c of the 2018 supplement to

the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall include **[**a**]** an annual or lifetime limit on the dollar value of benefits for a covered individual, for covered benefits that are essential health benefits, as defined in (1) the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, or regulations adopted thereunder, or (2) section 1 of this act, or regulations adopted thereunder.

Sec. 10. Subsection (a) of section 38a-512c of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall include **[**a**]** an annual or lifetime limit on the dollar value of benefits for a covered individual, for covered benefits that are essential health benefits, as defined in (1) the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, or regulations adopted thereunder, or (2) section 2 of this act, or regulations adopted thereunder.

Sec. 11. Section 38a-503e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**that provides coverage for outpatient prescription drugs approved by the federal Food and Drug Administration shall not exclude coverage for prescription contraceptive methods approved by the federal Food and Drug Administration.**]** shall provide coverage for

the following benefits and services:

(1) All contraceptive drugs, including, but not limited to, all over-the-counter contraceptive drugs, approved by the federal Food and Drug Administration. Such policy may require an insured to use, prior to using a contraceptive drug prescribed to the insured, a contraceptive drug that the federal Food and Drug Administration has designated as therapeutically equivalent to the contraceptive drug prescribed to the insured, unless otherwise determined by the insured's prescribing health care provider.

(2) All contraceptive devices and products, excluding all over-the-counter contraceptive devices and products, approved by the federal Food and Drug Administration. Such policy may require an insured to use, prior to using a contraceptive device or product prescribed to the insured, a contraceptive device or product that the federal Food and Drug Administration has designated as therapeutically equivalent to the contraceptive device or product prescribed to the insured, unless otherwise determined by the insured's prescribing health care provider.

(3) If a contraceptive drug, device or product described in subdivision (1) or (2) of this subsection is prescribed by a licensed physician, physician assistant or advanced practice registered nurse, a twelve-month supply of such contraceptive drug, device or product dispensed at one time or at multiple times, unless the insured or the insured's prescribing health care provider requests less than a twelve-month supply of such contraceptive drug, device or product. No insured shall be entitled to receive a twelve-month supply of a contraceptive drug, device or product pursuant to this subdivision more than once during any policy year.

(4) All sterilization methods approved by the federal Food and Drug Administration for women.

(5) Routine follow-up care concerning contraceptive drugs, devices and products approved by the federal Food and Drug Administration.

(6) Counseling in (A) contraceptive drugs, devices and products approved by the federal Food and Drug Administration, and (B) the proper use of contraceptive drugs, devices and products approved by the federal Food and Drug Administration.

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection (a), except that any such policy that uses a provider network may require cost-sharing when such benefits and services are rendered by an out-of-network provider. The cost-sharing limits imposed under this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493, to the maximum extent permitted by federal law, except if such plan is used to establish a health savings account, as that term is used in Section 223 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 223.

[(b)**]** (c) (1) Notwithstanding any other provision of this section, any insurance company, hospital service corporation, medical service corporation, or health care center may issue to a religious employer an individual health insurance policy that excludes coverage for **[**prescription contraceptive methods**]** benefits and services required under subsection (a) of this section that are contrary to the religious employer's bona fide religious tenets.

(2) Notwithstanding any other provision of this section, upon the written request of an individual who states in writing that **[**prescription contraceptive methods**]** benefits and services required under subsection (a) of this section are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to the individual an individual health insurance policy that

excludes coverage for **[**prescription contraceptive methods**]** benefits and services required under subsection (a) of this section.

[(c)**]** (d) Any health insurance policy issued pursuant to subsection **[**(b)**]** (c) of this section shall provide written notice to each insured or prospective insured that **[**prescription contraceptive methods**]** benefits and services required under subsection (a) of this section are excluded from coverage pursuant to **[**said**]** subsection (c) of this section. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

[(d)**]** (e) Nothing in this section shall be construed as authorizing an individual health insurance policy to exclude coverage for prescription contraceptive drugs, devices and products ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes.

[(e)**]** (f) Notwithstanding any other provision of this section, any insurance company, hospital service corporation, medical service corporation or health care center that is owned, operated or substantially controlled by a religious organization that has religious or moral tenets that conflict with the requirements of this section may provide for the coverage of **[**prescription contraceptive methods**]** benefits and services as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other **[**prescription**]** coverage offered to the insured.

[(f)**]** (g) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121 or a church-affiliated organization.

Sec. 12. Section 38a-530e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2019*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-

469 delivered, issued for delivery, renewed, amended or continued in this state **[**that provides coverage for outpatient prescription drugs approved by the federal Food and Drug Administration shall not exclude coverage for prescription contraceptive methods approved by the federal Food and Drug Administration.**]** shall provide coverage for the following benefits and services:

(1) All contraceptive drugs, including, but not limited to, all over-the-counter contraceptive drugs, approved by the federal Food and Drug Administration. Such policy may require an insured to use, prior to using a contraceptive drug prescribed to the insured, a contraceptive drug that the federal Food and Drug Administration has designated as therapeutically equivalent to the contraceptive drug prescribed to the insured, unless otherwise determined by the insured's prescribing health care provider.

(2) All contraceptive devices and products, excluding all over-the-counter contraceptive devices and products, approved by the federal Food and Drug Administration. Such policy may require an insured to use, prior to using a contraceptive device or product prescribed to the insured, a contraceptive device or product that the federal Food and Drug Administration has designated as therapeutically equivalent to the contraceptive device or product prescribed to the insured, unless otherwise determined by the insured's prescribing health care provider.

(3) If a contraceptive drug, device or product described in subdivision (1) or (2) of this subsection is prescribed by a licensed physician, physician assistant or advanced practice registered nurse, a twelve-month supply of such contraceptive drug, device or product dispensed at one time or at multiple times, unless the insured or the insured's prescribing health care provider requests less than a twelve-month supply of such contraceptive drug, device or product. No insured shall be entitled to receive a twelve-month supply of a contraceptive drug, device or product pursuant to this subdivision more than once during any policy year.

(4) All sterilization methods approved by the federal Food and Drug Administration for women.

(5) Routine follow-up care concerning contraceptive drugs, devices and products approved by the federal Food and Drug Administration.

(6) Counseling in (A) contraceptive drugs, devices and products approved by the federal Food and Drug Administration, and (B) the proper use of contraceptive drugs, devices and products approved by the federal Food and Drug Administration.

(b) No policy described in subsection (a) of this section shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for the benefits and services required under said subsection (a), except that any such policy that uses a provider network may require cost-sharing when such benefits and services are rendered by an out-of-network provider. The cost-sharing limits imposed under this subsection shall apply to a high deductible plan, as that term is used in subsection (f) of section 38a-493, to the maximum extent permitted by federal law, except if such plan is used to establish a health savings account, as that term is used in Section 223 of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as amended from time to time, the provisions of this subsection shall apply to such plan to the maximum extent that (1) is permitted by federal law, and (2) does not disqualify such account for the deduction allowed under said Section 223.

[(b)**]** (c) (1) Notwithstanding any other provision of this section, any insurance company, hospital service corporation, medical service corporation or health care center may issue to a religious employer a group health insurance policy that excludes coverage for **[**prescription contraceptive methods**]** benefits and services required under subsection (a) of this section that are contrary to the religious employer's bona fide religious tenets.

(2) Notwithstanding any other provision of this section, upon the written request of an individual who states in writing that

[prescription contraceptive methods**]** benefits and services required under subsection (a) of this section are contrary to such individual's religious or moral beliefs, any insurance company, hospital service corporation, medical service corporation or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for **[**prescription contraceptive methods**]** benefits and services required under subsection (a) of this section.

[(c)**]** (d) Any health insurance policy issued pursuant to subsection **[**(b)**]** (c) of this section shall provide written notice to each insured or prospective insured that **[**prescription contraceptive methods**]** benefits and services required under subsection (a) of this section are excluded from coverage pursuant to **[**said**]** subsection (c) of this section. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy.

[(d)**]** (e) Nothing in this section shall be construed as authorizing a group health insurance policy to exclude coverage for prescription contraceptive drugs, devices and products ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes.

[(e)**]** (f) Notwithstanding any other provision of this section, any insurance company, hospital service corporation, medical service corporation or health care center that is owned, operated or substantially controlled by a religious organization that has religious or moral tenets that conflict with the requirements of this section may provide for the coverage of **[**prescription contraceptive methods**]** benefits and services as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other **[**prescription**]** coverage offered to the insured.

[(f)**]** (g) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121 or a church-affiliated organization."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2019*	New section
Sec. 2	*January 1, 2019*	New section
Sec. 3	*January 1, 2019*	New section
Sec. 4	*January 1, 2019*	New section
Sec. 5	*January 1, 2019*	New section
Sec. 6	*January 1, 2019*	New section
Sec. 7	*January 1, 2019*	New section
Sec. 8	*January 1, 2019*	New section
Sec. 9	*January 1, 2019*	38a-482c(a)
Sec. 10	*January 1, 2019*	38a-512c(a)
Sec. 11	*January 1, 2019*	38a-503e
Sec. 12	*January 1, 2019*	38a-530e