



General Assembly

February Session, 2018

**Amendment**

LCO No. 4243



Offered by:

REP. SCANLON, 98<sup>th</sup> Dist.  
REP. PORTER, 94<sup>th</sup> Dist.  
REP. CONLEY, 40<sup>th</sup> Dist.  
REP. LINEHAN, 103<sup>rd</sup> Dist.

REP. SIMMONS, 144<sup>th</sup> Dist.  
REP. MCCARTHY VAHEY, 133<sup>rd</sup>  
Dist.  
SEN. FLEXER, 29<sup>th</sup> Dist.  
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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."**

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

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

6 (1) Ambulatory patient services;

7 (2) Emergency services;

8 (3) Hospitalization;

9 (4) Maternity and newborn health care;

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

12 (6) Prescription drugs;

13 (7) Rehabilitative and habilitative services and devices;

14 (8) Laboratory services;

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

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

19 (b) Each individual health insurance policy providing coverage of  
20 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
21 38a-469 of the general statutes delivered, issued for delivery, amended,  
22 renewed or continued in this state on or after January 1, 2019, shall  
23 provide coverage for essential health benefits.

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

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

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

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

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

41 (A) Ambulatory patient services;

42 (B) Emergency services;

43 (C) Hospitalization;

44 (D) Maternity and newborn health care;

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

47 (F) Prescription drugs;

48 (G) Rehabilitative and habilitative services and devices;

49 (H) Laboratory services;

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

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

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

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

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

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

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

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

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

88 Sec. 3. (NEW) (*Effective January 1, 2019*) (a) (1) Except as provided in  
89 subdivision (2) of this subsection, each individual health insurance  
90 policy providing coverage of the type specified in subdivisions (1), (2),  
91 (4), (11) and (12) of section 38a-469 of the general statutes delivered,  
92 issued for delivery, renewed, amended or continued in this state shall  
93 provide coverage for the following benefits and services:

- 94 (A) Domestic and interpersonal violence screening and counseling  
95 for any woman;
- 96 (B) Tobacco use intervention and cessation counseling for any  
97 woman who consumes tobacco;
- 98 (C) Well-woman visits for any woman who is younger than sixty-  
99 five years of age;
- 100 (D) Breast cancer chemoprevention counseling for any woman who  
101 is at increased risk for breast cancer due to family history or prior  
102 personal history of breast cancer, positive genetic testing or other  
103 indications as determined by such woman's physician or advanced  
104 practice registered nurse;
- 105 (E) Breast cancer risk assessment, genetic testing and counseling;
- 106 (F) Chlamydia infection screening for any sexually-active woman;
- 107 (G) Cervical and vaginal cancer screening for any sexually-active  
108 woman;
- 109 (H) Gonorrhea screening for any sexually-active woman;
- 110 (I) Human immunodeficiency virus screening for any sexually-  
111 active woman;
- 112 (J) Human papillomavirus screening for any woman with normal  
113 cytology results who is thirty years of age or older;
- 114 (K) Sexually transmitted infections counseling for any sexually-  
115 active woman;
- 116 (L) Anemia screening for any pregnant woman and any woman  
117 who is likely to become pregnant;
- 118 (M) Folic acid supplements for any pregnant woman and any  
119 woman who is likely to become pregnant;

- 120 (N) Hepatitis B screening for any pregnant woman;
- 121 (O) Rhesus incompatibility screening for any pregnant woman and  
122 follow-up rhesus incompatibility testing for any pregnant woman who  
123 is at increased risk for rhesus incompatibility;
- 124 (P) Syphilis screening for any pregnant woman and any woman  
125 who is at increased risk for syphilis;
- 126 (Q) Urinary tract and other infection screening for any pregnant  
127 woman;
- 128 (R) Breastfeeding support and counseling for any pregnant or  
129 breastfeeding woman;
- 130 (S) Breastfeeding supplies, including, but not limited to, a breast  
131 pump for any breastfeeding woman;
- 132 (T) Gestational diabetes screening for any woman who is twenty-  
133 four to twenty-eight weeks pregnant and any woman who is at  
134 increased risk for gestational diabetes;
- 135 (U) Osteoporosis screening for any woman who is sixty years of age  
136 or older;
- 137 (V) Such additional evidence-based items or services not described  
138 in subparagraphs (A) to (U), inclusive, of this subdivision that receive  
139 a rating of "A" or "B" in any recommendations of the United States  
140 Preventive Services Task Force effective after January 1, 2018; and
- 141 (W) With respect to infants, children and adolescents, evidence-  
142 informed preventive care and screenings provided for in the  
143 comprehensive guidelines supported by the United States Health  
144 Resources and Services Administration, as effective on January 1, 2018,  
145 and such additional preventive care and screenings provided for in  
146 any comprehensive guidelines supported by said administration and  
147 effective after January 1, 2018.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

204 (N) Hepatitis B screening for any pregnant woman;

205 (O) Rhesus incompatibility screening for any pregnant woman and



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

371 (a) No individual health insurance policy providing coverage of the  
372 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-  
373 469 delivered, issued for delivery, amended, renewed or continued in  
374 this state shall include [a] an annual or lifetime limit on the dollar  
375 value of benefits for a covered individual, for covered benefits that are  
376 essential health benefits, as defined in (1) the Patient Protection and  
377 Affordable Care Act, P.L. 111-148, as amended from time to time, or  
378 regulations adopted thereunder, or (2) section 1 of this act, or  
379 regulations adopted thereunder.

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

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

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

394 (a) Each individual health insurance policy providing coverage of  
395 the type specified in subdivisions (1), (2), (4), (11) and (12) of section  
396 38a-469 delivered, issued for delivery, renewed, amended or continued  
397 in this state [that provides coverage for outpatient prescription drugs  
398 approved by the federal Food and Drug Administration shall not  
399 exclude coverage for prescription contraceptive methods approved by  
400 the federal Food and Drug Administration.] shall provide coverage for

401 the following benefits and services:

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

497 469 delivered, issued for delivery, renewed, amended or continued in  
498 this state [that provides coverage for outpatient prescription drugs  
499 approved by the federal Food and Drug Administration shall not  
500 exclude coverage for prescription contraceptive methods approved by  
501 the federal Food and Drug Administration.] shall provide coverage for  
502 the following benefits and services:

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

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

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

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

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

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

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

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

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

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

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

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

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

591 [(f)] (g) As used in this section, "religious employer" means an  
592 employer that is a "qualified church-controlled organization" as  
593 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	<i>January 1, 2019</i>	New section
Sec. 2	<i>January 1, 2019</i>	New section
Sec. 3	<i>January 1, 2019</i>	New section
Sec. 4	<i>January 1, 2019</i>	New section
Sec. 5	<i>January 1, 2019</i>	New section
Sec. 6	<i>January 1, 2019</i>	New section
Sec. 7	<i>January 1, 2019</i>	New section
Sec. 8	<i>January 1, 2019</i>	New section
Sec. 9	<i>January 1, 2019</i>	38a-482c(a)
Sec. 10	<i>January 1, 2019</i>	38a-512c(a)
Sec. 11	<i>January 1, 2019</i>	38a-503e
Sec. 12	<i>January 1, 2019</i>	38a-530e