OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

ResearchReport

# State-Mandated Health Insurance Benefits

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## Issue

This report lists and briefly describes Connecticut's mandated health insurance benefits for fully insured commercial health insurance policies and plans. It updates OLR Report 2024-R-0158 to reflect legislation enacted in 2025.

## Summary

A mandated health insurance benefit is a state requirement that a fully insured commercial health insurance policy or plan cover a specified benefit or service.

In Connecticut, most mandates apply to both individual and group health insurance policies, including HMO plans. However, due to the federal Employee Retirement Income Security Act (ERISA), state benefit mandates generally do not apply to self-insured health plans.

Although the state employee health insurance plan is self-insured, in practice it incorporates all state mandated benefits and services.

### *Related OLR Reports*

*OLR Report 2025-R-0103 identifies laws affecting insurance that were enacted in 2025.*

*OLR Report 2020-R-0214 explains federal preemption of state benefit mandates under ERISA.*

*OLR Report 2022-R-0100 provides a list of health care providers and facilities whose services health insurance policies and HMO contracts must cover under state law (i.e. provider and facility mandates).*

In 2025, the legislature enacted or amended the following health insurance benefit mandates:

1. biomarker testing coverage (PA 25-16, §§ 4 & 5) (effective January 1, 2026);
2. general anesthesia reimbursement (PA 25-94, §§ 8 & 9) (effective January 1, 2026); and
3. wheelchair repairs, by allowing rather than requiring the insurance commissioner to adopt related regulations (PA 25-132, §§ 3 & 4) (effective upon passage).

## Connecticut's Mandated Health Insurance Benefits

Table 1 below lists and briefly describes Connecticut's mandated health insurance benefits in alphabetical order by topic. It provides the statutory citation for each and indicates if the mandate generally applies to individual plans, group plans, or both. For full details of a mandated benefit, refer to the cited statute(s).

**Table 1: Connecticut's Mandated Health Insurance Benefits (as of January 1, 2026)***

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-498a<br>38a-525a | 9-1-1 Calls – Prior Authorization | Both | Cannot require prior authorization for a 9-1-1 call for a life or limb threatening emergency. |
| 38a-492<br>38a-518 | Accidental Ingestion or Consumption of Controlled Drugs | Both | Emergency medical care for the accidental ingestion or consumption of controlled drugs. Coverage is subject to a minimum of 30 days inpatient care and a maximum $500 for outpatient care per calendar year. |
| 38a-533 | Alcoholism Complications | Group | Expenses incurred in connection with medical complications of alcoholism such as cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and delirium tremens. |
| 38a-498<br>38a-525 | Ambulance Services | Both | Policies must cover medically necessary ambulance services. Payment must be on a direct pay basis where notice of assignment is reflected on the bill. |
| 38a-498a<br>38a-525a | Ambulance Services – Prior Authorization | Both | Cannot require prior authorization for ambulance transport to a hospital when medically necessary. |
| 38a-488b<br>38a-514b | Autism Spectrum Disorder | Both | Policies must cover the diagnosis and treatment of autism spectrum disorders, including (1) behavioral therapy for a person age 20 or younger and (2) certain prescription drugs and psychiatric and psychological services. |
| PA 25-16, §§ 4 & 5 | Biomarker Testing | Both | Policies must cover biomarker testing to diagnose, treat, manage, and monitor patient diseases or conditions. The use of testing must be supported by medical and scientific evidence. A policy may require that biomarker testing must be performed at an in-network clinical laboratory. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-490a<br>38a-516a | Birth-to-Three Services | Both | Early intervention services provided as part of an individualized family service plan.<br><br>Policy cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses, unless it is a high deductible health plan (HDHP). |
| 38a-492o<br>38a-518o | Bone Marrow Testing | Both | Policies must cover compatibility testing for bone marrow transplants for people who join the National Marrow Donor Program.<br><br>Policy cannot impose coinsurance, copayments, deductibles, or other out-of-pocket expenses in excess of 20%, unless a HDHP. |
| 38a-503<br>38a-530 | Breast Cancer Screening and Related Services | Both | Coverage for diagnostic and screening mammograms for insureds. This includes a baseline mammogram for an insured who is (1) age 35 to 39 or (2) under age 35 and at increased risk for breast cancer. It also includes an annual mammogram for an insured who is (1) age 40 or older or (2) under age 40 and at increased risk for breast cancer. (A mammogram may be provided by breast tomosynthesis at the insured's option.)<br><br>Coverage for comprehensive diagnostic and screening ultrasounds of an insured's entire breast(s) if the insured has (1) heterogeneous or dense breast tissue or (2) an increased risk of breast cancer.<br><br>Coverage for diagnostic and screening magnetic resonance imaging (MRI) of an insured's entire breast(s) in accordance with American Cancer Society guidelines for an insured who is (1) age 35 or older or (2) under age 35 and at increased risk for breast cancer.<br><br>Coverage for breast biopsies, certain prophylactic mastectomies, and breast reconstructive surgery following a mastectomy.<br><br>Policy cannot impose patient cost sharing (i.e. coinsurance, copayment, deductible, or other out-of-pocket expense) for these benefits. (This applies to a HDHP to the extent federal law permits.) |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-542 | Breast Implant Removal | Group | Medically necessary removal of breast implants implanted on or before July 1, 1994. Annual coverage must be at least $1,000. |
| 38a-504<br>38a-542 | Breast Reconstruction After Mastectomy | Both | Reconstructive surgery after mastectomy and on non-diseased breast for symmetrical appearance. Coverage is subject to the same terms and conditions as other benefits under the policy. |
| 38a-504a – 38a-504g;<br>38a-542a – 38a-542g | Cancer and Other Clinical Trials | Both | Routine patient costs relating to clinical trials for cancer and disabling or life-threatening chronic diseases. Out-of-network hospitalization paid as in-network benefit if services are not available in network. |
| 38a-497<br>38a-512b | Children – Covered to Age 26 | Both | Coverage continues at least until the policy anniversary date on or after the date the child turns age 26, or if covered by a state employee health plan, gets coverage under his or her employer's group health plan. |
| 38a-489<br>38a-515 | Children – Mentally or Physically Handicapped | Both | Coverage must continue beyond the dependent age if the child is both mentally or physically handicapped and dependent upon the insured for support. |
| 38a-490<br>38a-508<br>38a-516<br>38a-549 | Children – Newborns and Adopted | Both | Injury and sickness, including care and treatment of congenital defects and birth abnormalities, for newborns from birth and for adopted children from legal placement for adoption.<br><br>Newborns are covered for 91 days. Adopted children are covered for 31 days. To extend coverage, insureds must give notification and premium payment to the insurer. |
| 38a-497<br>38a-512b | Children – Stepchildren | Both | Policies must cover stepchildren on the same basis as biological children. |
| 38a-492*l*<br>38a-516d | Children With Cancer – Neurological Testing | Both | Coverage for neuropsychological testing a physician orders to assess if chemotherapy or radiation treatment caused cognitive or developmental delays. Insurers cannot require pre-authorization for the tests. |
| 38a-507<br>38a-534 | Chiropractic Services | Both | Cover chiropractor services to same extent as coverage for a physician. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-492k<br>38a-518k | Colorectal Cancer Screening | Both | Cover colorectal cancer screening in accordance with American Cancer Society recommendations.<br><br>Cannot impose coinsurance, copayment, deductible, or other out-of-pocket expense for any additional colonoscopy a physician orders for an insured person in a policy year, excluding HDHPs.<br><br>Cannot impose a deductible for a procedure initially undertaken as a screening colonoscopy or screening sigmoidoscopy. |
| 38a-503e<br>38a-530e | Contraceptive Benefits, Sterilization, and Related Services | Both | Policies must cover Food and Drug Administration (FDA)-approved contraceptive drugs, devices, and products; sterilization methods for women; routine follow-up care; and related counseling. Policies must cover a 12-month supply of an FDA-approved contraceptive drug, device, or product prescribed by a licensed physician, physician assistant, or advanced practice registered nurse. An individual or religious employer may decline coverage for contraceptive benefits and services if contrary to their bona fide religious tenets.<br><br>Coverage must be provided in full, with no cost sharing, except policies may impose cost sharing when an out-of-network provider renders the benefits and services. |
| 38a-492x<br>38a-518x | Coronary Calcium Scans | Both | Policies must cover coronary calcium scans (i.e. a computed tomography scan of the heart that looks for calcium deposits in the heart arteries). |
| 38a-490c<br>38a-516c | Craniofacial Disorders | Both | Medically necessary orthodontic processes and appliances for treatment of craniofacial disorders for people age 18 or younger. Coverage for cosmetic surgery is not required. |
| 38a-491a<br>38a-517a | Dental Coverage | Both | Medically necessary general anesthesia, nursing, and related hospital services for in-patient, outpatient, or one-day dental services. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-492d<br>38a-518d | Diabetes | Both | Treatment of all types of diabetes, including coverage for medically necessary laboratory and diagnostic testing and screening, insulin drugs, noninsulin drugs, diabetes devices, diabetes ketoacidosis devices, and certain emergency insulin and supplies.<br><br>Cannot impose coinsurance, copays, deductibles, or out-of-pocket expenses that are more than the following: (1) $25 for a 30-day supply of insulin or noninsulin drugs and (2) $100 for a 30-day supply of diabetes devices or diabetes ketoacidosis devices.<br><br>(See Insurance Department Bulletin HC-129 (April 7, 2021) for discussion.) |
| 38a-492e<br>38a-518e | Diabetes Self-Management Training | Both | Outpatient self-management training prescribed by a licensed health care professional. Coverage is subject to the same terms and conditions as other policy benefits. |
| 38a-478r | Emergency Medical Conditions | Both | Policies must cover medically necessary health care services for emergency medical conditions. |
| 38a-477aa | Emergency Services | Both | Cannot require prior authorization for emergency services. Cannot impose a cost sharing level for out-of-network services that is greater than the in-network level. |
| 38a-492n<br>38a-518m | Epidermolysis Bullosa | Both | Policies must cover wound care supplies that are medically necessary to treat epidermolysis bullosa (a rare skin disorder) and administered under a physician's direction. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-492q<br>38a-492r<br>38a-492s<br>38a-503f<br>38a-530f**<br>38a-518q<br>38a-518r**<br>38a-518s** | Essential Health Benefits and Preventive Health Services, Including Immunizations | Individual and Small Employer Group Plans (** applies to group plans generally) | Policies must cover the following 10 essential health benefits and cannot include annual or lifetime limits on their dollar value: ambulatory patient services, emergency services, hospitalization, maternity and newborn health care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric services.<br><br>Policies must also cover (1) specified preventive health care services, including evidence-based items and services recommended by the U.S. Preventive Services Task Force with an "A" or "B" rating; (2) immunizations recommended by specified sources; and (3) pediatric preventive care and screenings in accordance with the American Academy of Pediatrics recommendations.<br><br>Coverage for these must be provided in full, with no cost sharing, except policies may impose cost sharing when an out-of-network provider renders the benefits and services. |
| 38a-483c<br>38a-513b | Experimental Treatments | Both | Procedures, treatments, or drugs that have completed a Phase III FDA clinical trial. |
| PA 25-94, §§ 8 & 9 | General Anesthesia Reimbursement | Both | A policy that covers general anesthesia cannot (1) impose an arbitrary time limit on reimbursement of general anesthesia during a medically necessary procedure or (2) deny, reduce, terminate, or fail to provide reimbursement for it solely because its duration exceeds the insurer's predetermined time limit for care. |
| 38a-490b<br>38a-516b | Hearing Aids | Both | Coverage for hearing aids. Coverage may be limited to one hearing aid per ear within a 24-month period. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-493<br>38a-520 | Home Health Care | Both | Home health care, including (1) part-time or intermittent nursing care and home health aide services; (2) physical, occupational, or speech therapy; (3) medical supplies, drugs, and medicines; and (4) (for terminally ill patients) medical social services.<br><br>Coverage can be limited to no less than 80 visits per year and, for a terminally ill person, no more than $200 for medical social services. Coverage can be subject to an annual deductible of up to $50 (excluding HDHPs) and a coinsurance provision covering at least 75%. |
| 38a-492a<br>38a-518a | Hypodermic Needles and Syringes | Both | Hypodermic needles and syringes prescribed by a practitioner for administering medications. |
| 38a-511<br>38a-550 | Imaging Services (MRIs, CAT Scans, and PET Scans) – Copays | Both | Limits copays for in-network MRIs and CAT scans to (1) $375 for all such services annually and (2) $75 for each one. Limits copays for in-network PET scans to (1) $400 for all such scans annually and (2) $100 for each one. Limits not applicable (1) if the ordering physician performs the service or is in the same practice group as the one who does and (2) to HDHPs or copayment-only health plans. |
| 38a-492r<br>38a-518r | Immunization Consultations | Both | Policies covering prescription drugs must cover at least a 20-minute immunization consultation between a patient and a provider authorized to administer immunizations. Coverage applies for immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices for the patient. |
| 38a-509<br>38a-536 | Infertility | Both | Medically necessary costs of diagnosing and treating infertility, subject to certain limits. Cannot discriminate on the basis of gender identity or expression, sexual orientation, or age (but age may be a factor in determining medical necessity under certain guidelines). |
| 38a-492v<br>38a-518v | In-home Hospice Services | Both | Policies must cover in-home hospice services provided by a Department of Public Health-licensed hospice home care agency to the same extent they cover hospital in-patient hospice services and subject to the same terms and conditions that apply to other policy benefits. Cannot exclude coverage for a hospice service solely because it is provided in the home and not at a hospital, as long as the service is appropriate for the insured. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-498c<br>38a-525c | Injured and Under the Influence | Both | Policies are prohibited from denying coverage for health care services if the injury is alleged to have occurred or occurs when the person has an elevated blood alcohol level (0.08% or more) or is under the influence of drugs or alcohol. |
| 38a-490d<br>38a-535 | Lead Screening | Both | Coverage for blood lead screening and risk assessments ordered by primary care providers in accordance with the law. |
| 38a-501 | Long-Term Care Policy – Elimination Period | Individual | Requires an elimination period (i.e. a waiting period after the onset of the injury, illness, or function loss during which no benefits are payable) that is (1) up to 100 days of confinement or (2) between 100 days and two years of confinement if an irrevocable trust is in place sufficient to cover the person's confinement costs during this period. Establishes trust requirements. |
| 38a-501 | Long-Term Care Policy – Non-Forfeiture | Individual | Prohibits an insurer from issuing or delivering a long-term care policy on or after July 1, 2008, unless it offers the prospective insured an optional non-forfeiture benefit. If the non-forfeiture option is declined, the insurer must give the insured a contingent benefit upon lapse. |
| 38a-492h<br>38a-518h | Lyme Disease Treatment | Both | Lyme disease treatment including not less than 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and further treatment if recommended by a rheumatologist, infectious disease specialist, or neurologist. |
| 38a-503d<br>38a-530d | Mastectomy Care | Both | Minimum 48-hour hospital stay after mastectomy or lymph node dissection or longer stay if recommended by physician. |
| 38a-503c<br>38a-530c | Maternity Care | Both | Minimum 48-hour hospital stay for mother and newborn after vaginal delivery and minimum 96-hour hospital stay after caesarian delivery. If discharged earlier, policy must cover certain follow up care. |
| 38a-488g<br>38a-514g | Mental Health – Acute Inpatient Psychiatric Services | Both | Cannot require prior authorization for acute inpatient psychiatric services provided (1) after an emergency department admission, (2) at a Department of Children and Families (DCF)-certified urgent crisis center, or (3) by referral from a treating provider if the insured poses an imminent danger to self or others. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-488f<br>38a-514f | Mental Health – Collaborative Care Model Services | Both | Coverage for health care services a primary care provider provides to an insured under the Collaborative Care Model (i.e. an integrated delivery of behavioral health and primary care services by a primary care team). |
| 38a-477aa | Mental Health – Urgent Crisis Center Services | Both | Cannot require prior authorization for pediatric mental and behavioral health services provided at DCF-certified urgent crisis centers.<br><br>Cannot impose a cost sharing level for out-of-network services that is greater than the in-network level. |
| 38a-488c<br>38a-514c | Mental Health and Substance Use Disorders – Non-Quantitative Treatment Limitations | Both | Policies cannot apply non-quantitative treatment limitations (i.e. non-numeric limits on the scope or duration of coverage, such as prior authorization requirements) to mental health and substance use disorder benefits unless they apply the limitations comparably to, and not more stringently than, how it applies them to medical and surgical benefits. |
| 38a-488e<br>38a-514e | Mental Health Wellness Exams | Both | Coverage for two mental health wellness exams per year, conducted by a licensed mental health professional. Policies cannot impose patient cost sharing or prior authorization requirements. |
| 38a-488a<br>38a-514 | Mental or Nervous Conditions | Both | Coverage for the diagnosis and treatment of mental or nervous conditions. (Minimum benefits specified in statute.) Coverage cannot (1) differ from the terms, conditions, or benefits for the diagnosis or treatment of medical, surgical, or other physical health conditions or (2) prohibit multiple screening services as part of a single day visit to a provider or multi-care institution. |
| 38a-498b<br>38a-525b | Mobile Field Hospitals | Both | Benefits for isolation care and emergency services provided by mobile field hospitals, previously called critical access hospitals. These benefits are subject to any policy provisions that apply to other covered services. The rates a policy pays must be equal to the rates Medicaid pays, as determined by the Department of Social Services. |
| 38a-503c(e)<br>38a-530c(e) | Newborn Infants and Their Mothers | Both | Cannot require preauthorization for an inter-hospital transfer of (1) a newborn infant with a life-threatening emergency or condition or (2) the infant's hospitalized mother to accompany him or her. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-503b<br>38a-530b | Obstetrician – Gynecologist; Pap Smear | Both | Direct access to participating in-network OB-GYN for gynecological examination, pregnancy care, and primary and preventive obstetric and gynecologic services required as result of a gynecological examination or condition (includes pap smear). Female enrollees may also designate participating OB-GYN or other doctor as primary care provider. |
| 38a-496<br>38a-524 | Occupational Therapy | Both | If policy covers physical therapy, it must provide coverage for occupational therapy. |
| 38a-511a<br>38a-550a | Occupational Therapy Services – Copays | Both | A policy cannot impose a copayment of more than $30 per visit for in-network occupational therapy services performed by a state-licensed occupational therapist. Limit not applicable to copayment-only health plans. |
| 38a-492b<br>38a-518b | Off-Label Prescription Drugs | Both | If a prescription drug is recognized for treatment of a specific type of cancer or disabling or life threatening chronic disease, a policy cannot exclude coverage of the drug when it is used for another type of cancer or disease under certain circumstances. |
| 38a-504(d)<br>38a-542(d) | Oral Chemotherapy | Both | Policies that cover intravenously and orally administered anti-cancer medications must cover the orally administered medication on at least as favorable a basis as the intravenously administered medication. |
| 38a-492j<br>38a-518j | Ostomy Appliances and Supplies | Both | If policy covers ostomy surgery, it must also cover medically necessary ostomy-related appliances and supplies, up to $2,500 per year. |
| 38a-503g<br>38a-530g | Ovarian Cancer Screening and Related Services | Both | Coverage for (1) genetic testing for insureds with a family history of breast or ovarian cancer; (2) routine screening for ovarian cancer, including office visit, and annual surveillance tests for insureds at risk; (3) CA-125 monitoring of ovarian cancer following treatment; and (4) genetic testing of BRCA1, BRCA2, and other gene variants that increase risk of gynecological cancer when recommended by a healthcare provider.<br><br>Policies cannot impose patient cost sharing (i.e. coinsurance, copayment, deductible, or other out-of-pocket expense) for these benefits. (This applies to a HDHP to the extent federal law permits.) |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-492i<br>38a-518i | Pain Management | Both | Access to a pain management specialist and coverage for pain treatment ordered by the specialist.<br><br>Cannot require an insured person to use an alternative brand name prescription or over-the-counter drug before using a brand name prescription drug prescribed by a licensed physician for pain management. |
| 38a-511a<br>38a-550a | Physical Therapy Services – Copays | Both | A policy cannot impose a copayment of more than $30 per visit for in-network physical therapy services performed by a state-licensed physical therapist. Limit not applicable to copayment-only health plans. |
| 38a-476 | Preexisting Condition Coverage | Both | May not impose a preexisting condition provision on any person. |
| 38a-492f<br>38a-518f | Prescription Drugs Removed From Formulary | Both | Coverage for a prescription drug that has been removed from the list of covered drugs must be continued if the insured was previously using the drug for the treatment of a chronic illness and it is deemed medically necessary. (Also see CGS § 38a-477jj.) |
| 38a-492m<br>38a-518*l* | Prescription Eye Drops | Both | Policies that provide prescription eye drop coverage cannot deny coverage for prescription renewals when the (1) refill is requested by the insured person less than 30 days from either the (a) date the original prescription was given to the insured or (b) last date the prescription refill was given to the insured, whichever is later, and (2) prescribing provider notes that additional quantities are needed and the refill request does not exceed this amount. |
| 38a-510b<br>38a-544b | Prescription Opioid Antagonists | Both | Cannot require preauthorization for naloxone hydrochloride or any other similarly acting and equally safe drug (i.e. opioid antagonist) approved by the FDA for the treatment of drug overdose. |
| 38a-510a<br>38a-544a | Prescription Refills Synchronized | Both | Cannot deny coverage for refilling any drug prescribed to treat a chronic illness if the refill is made in accordance with a plan to synchronize the refilling of multiple prescriptions. |
| 38a-535 | Preventive Pediatric Care | Group | Preventive pediatric care at the following intervals: (1) every two months from birth to six months, (2) every three months from 9 to 18 months, and (3) annually from two to six years of age. Coverage is subject to any policy provisions that apply to other services covered under the policy. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-492g<br>38a-518g | Prostate Cancer Screening and Treatment | Both | Laboratory and diagnostic tests to screen for prostate cancer for men who are symptomatic, have a family history, or are over age 50.<br><br>Policy must cover medically necessary prostate cancer treatment in accordance with National Comprehensive Cancer Network, American Cancer Society, or American Society of Clinical Oncology guidelines. |
| 38a-492t<br>38a-518t | Prosthetic Devices | Both | Policies must cover prosthetic devices, and medically necessary repairs and replacements to them, subject to specified conditions. Coverage must be at least equivalent to the coverage Medicare provides for such devices. |
| 38a-492c<br>38a-518c | Protein Modified Food and Specialized Formula | Both | Coverage for (1) amino acid modified and low protein modified food products when prescribed for the treatment of inherited metabolic diseases and cystic fibrosis and (2) medically necessary specialized formula for children up to age 12. Food and formula must be administered under the direction of a physician. Coverage for preparations, food products, and formulas must be on the same basis as coverage for outpatient prescription drugs. |
| 38a-476b<br>38a-492u<br>38a-518u | Psychotropic Drugs | Both | A mental health care benefit provided under state law, with state funds, or to state employees may not limit the availability of the most effective psychotropic drugs in the supply the provider deems clinically appropriate.<br><br>Policies that cover outpatient prescription drugs cannot (1) require a health care provider to prescribe a supply of outpatient psychotropic drugs greater than that which he or she deems clinically appropriate or (2) impose a cost-sharing amount for a less than 90-day supply of these drugs that exceeds the 90-day, reduced pro-rata cost-sharing amount, provided the prescriber deems a 90-day supply clinically inappropriate. |
| 38a-477hh | Pulse Oximeter Readings | Both | Cannot deny coverage for an otherwise covered benefit if the denial is exclusively based on the insured's blood oxygen level as measured by a pulse oximeter. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-523 | Rehabilitation Services | Group | Insurers providing group health insurance must offer coverage for comprehensive rehabilitation services, including (1) physician services, physical and occupational therapy, nursing care, psychological and audiological services, and speech therapy; (2) social services provided by a social worker; (3) respiratory therapy; (4) prescription drugs and medicines; (5) prosthetic and orthotic devices; and (6) other prescribed supplies and services. |
| 38a-488d<br>38a-514d | Substance Abuse Services – Court Ordered | Both | Cannot deny covered substance abuse services solely because they are court ordered. |
| 38a-492p<br>38a-518p | Substance Use Disorder – Inpatient Detoxification Services | Both | For insureds or enrollees diagnosed with a substance use disorder, policies must cover medically necessary (1) medically monitored inpatient detoxification services and (2) medically managed intensive inpatient detoxification services. |
| 38a-499a<br>38a-526a | Telehealth Services – Coverage | Both | Policies must cover medical advice, diagnosis, care, or treatment provided through telehealth to the extent that they cover these services through in-person visits between an insured person and a specified Connecticut-licensed health care provider. |
| 38a-477mm | Telehealth Services – Reimbursement | Both | Carriers cannot reduce reimbursement to a provider because services are provided through telehealth instead of in person. |
| 38a-504(a) & (b)<br>38a-542(a) & (b) | Tumors and Leukemia and Wigs for Chemotherapy Patients | Both | Surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, non-dental prosthesis, surgical removal of breasts due to tumors, and a wig if prescribed by a licensed oncologist for a patient suffering hair loss from chemotherapy.<br><br>Annual coverage must be at least $500 for surgical tumor removal, $500 for reconstructive surgery, $500 for outpatient chemotherapy, $350 for a wig, and $300 for prosthesis, except for surgical removal of breasts due to tumors, the prosthesis benefit must be at least $300 for each breast removed. |

Table 1 (continued)

| CGS § | Mandate | Individual, Group, or Both | Description |
|---|---|---|---|
| 38a-492w<br>38a-518w<br><br>Amended by PA 25-132, §§ 3 & 4 | Wheelchair Repairs | Both | Policies cannot require a new prescription or prior authorization for a medically necessary repair or replacement of a complex rehabilitation technology wheelchair unless the original prescription is more than five years old. In this instance, "medically necessary" means a policyholder's health care provider's written determination that the repair or replacement is needed to preserve the policyholder's health. |

*Notes:

1. Some mandates require that services be "medically necessary." State law specifies the definition of "medically necessary" that policies must include (see CGS §§ 38a-482a & 38a-513c).

2. Section 2711 of the Affordable Care Act prohibits annual dollar limits on essential health benefits. The prohibition preempts Connecticut's statutory annual dollar limits for any mandated benefit that is part of Connecticut's essential health benefit package. For more information, see the Connecticut Insurance Department's Bulletins HC-90-14-2 (March 18, 2014) and HC-99 (August 20, 2014).

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