§ 4306-h. Essential health benefits package and limit on cost-sharing. (a) (1) For purposes of this article, "essential health benefits" shall mean the following categories of benefits:

(A) ambulatory patient services;

(B) emergency services;

(C) hospitalization;

(D) maternity and newborn care;

* (E) mental health and substance use disorder services, including behavioral health treatment;

* NB Effective until January 1, 2027

* (E) mental health and substance-related and addictive disorder services, including behavioral health treatment;

* NB Effective January 1, 2027

(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 oral and vision care.

(2) A corporation shall not be required to provide coverage for pediatric oral services as an essential health benefit if:

(A) for coverage offered through the exchange established by this state, the exchange has determined sufficient coverage of the pediatric oral benefit is available through stand-alone dental plans certified by the exchange; or

(B) for coverage offered outside the exchange, the corporation obtains reasonable written assurance that the individual or group has obtained a stand-alone dental plan that has been approved by the superintendent as meeting exchange certification standards.

(b) (1) Every individual and small group contract that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan shall provide coverage that meets the actuarial requirements of one of the following levels of coverage:

(A) Bronze Level. A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to sixty percent of the full actuarial value of the benefits provided under the plan;

(B) Silver Level. A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to seventy percent of the full actuarial value of the benefits provided under the plan;

(C) Gold Level. A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent of the full actuarial value of the benefits provided under the plan; or

(D) Platinum Level. A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to ninety percent of the full actuarial value of the benefits provided under the plan.

(2) The superintendent may provide for a variation in the actuarial values used in determining the level of coverage of a plan to account for the differences in actuarial estimates.

(3) Every student accident and health insurance contract shall provide coverage that meets at least sixty percent of the full actuarial value of the benefits provided under the contract. The contract's schedule of benefits shall include the level as described in paragraph one of this subsection nearest to, but below the actual actuarial value.

(c) Every individual or group contract that provides hospital, surgical, or medical expense coverage and is not a grandfathered health plan, and every student accident and health insurance contract shall limit the insured's cost-sharing for in-network services in a contract year to not more than the maximum out-of-pocket amount determined by the superintendent for all contracts subject to this section. Such amount shall not exceed any annual out-of-pocket limit on cost-sharing set by the United States secretary of health and human services, if available.

(d) The superintendent may require the use of model language describing the coverage requirements for any form that is subject to the approval of the superintendent pursuant to section four thousand three hundred eight of this article.

(e) For purposes of this section:

(1) "actuarial value" means the percentage of the total expected payments by the corporation for benefits provided to a standard population, without regard to the population to whom the corporation actually provides benefits;

(2) "cost-sharing" means annual deductibles, coinsurance, copayments, or similar charges, for covered services;

(3) "essential health benefits package" means coverage that:

(A) provides for essential health benefits;

(B) limits cost-sharing for such coverage in accordance with subsection (c) of this section; and

(C) provides one of the levels of coverage described in subsection (b) of this section;

(4) "grandfathered health plan" means coverage provided by a corporation in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e);

(5) "small group" means a group of one hundred or fewer employees or members exclusive of spouses and dependents; and

(6) "student accident and health insurance" shall have the meaning set forth in subsection (a) of section three thousand two hundred forty of this chapter.