HEFFERNAN INSURANCE BROKERS
Because You're Different

Health Insurance Mandates

State health insurance mandates are laws regulating the terms of coverage for insured health plans. Mandates can affect various parts of health insurance plans as follows:

- ✓ **Benefit mandates** require health insurance plans to cover specific treatments, services or procedures. In some cases, however, benefit mandates require issuers to offer coverage for specific services or procedures to employers.
- ✓ **Provider mandates** require health insurance plans to pay for services provided by specific health care professionals. Often, provider mandates are in the form of **nondiscrimination mandates** that require coverage only if the health plan already reimburses services within the scope of the health care professional's practice.
- ✓ **Person mandates** require health insurance plans to cover specific categories of people.

Additional mandates for health plans exist at the federal level. For instance, the Affordable Care Act (ACA) requires non-grandfathered plans in the small group and individual markets to provide coverage for items and services designated as "essential health benefits." Health plan sponsors and issuers should work with their advisors to determine how to comply with applicable federal and state mandates.

This Employment Law Summary contains a chart outlining New York's benefit, provider and person mandates for insured group health plans issued in the state. Please keep in mind that the following chart does not address federal benefit mandates, such as the ACA's mandates.

State Resources

- New York Department of Financial Services website
- New York's state insurance laws can be found here
- State mandated benefits for comprehensive health insurance contracts can be found here

Benefit Mandates

MANDATE	DESCRIPTION
Abortion coverage *New requirements effective May 3, 2023*	Effective Jan. 1, 2023, plans offering maternity care coverage must also provide coverage for abortion services. Coverage for abortion cannot be subject to annual deductibles or coinsurance, including co-payments, unless the policy is a high deductible health plan, in which case the coverage may be subject to the plan's annual deductible. Policies issued to religious employers may exclude coverage for abortion if certain conditions are met. Effective May 3, 2023, coverage for abortion must include coverage of any drug prescribed for the purpose of an abortion, including both generic and brand name drugs, even if such drug has not been approved by the federal FDA for abortion, provided, however, that such drug must be a recognized medication for abortion in established reference compendia set forth in the law.
Ambulatory care	Must make available and, if requested by the policyholder, provide coverage for ambulatory care in hospital outpatient facilities and physician offices. Ambulatory care generally includes services for diagnostic X-rays, laboratory and pathological examinations, radiation therapy, and services and medications used for non-experimental cancer chemotherapy and cancer hormone therapy. For care in hospital outpatient facilities, it also includes physical and occupational therapy.
Autism spectrum disorder	Coverage for the screening, diagnosis and treatment of autism spectrum disorder. The treatment of autism spectrum disorder includes the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • Behavioral health treatment; • Psychiatric and psychological care; • Medical care provided by a licensed health care provider; • Therapeutic care provided by social workers and speech, physical and occupational therapists, including therapeutic care which is deemed habilitative or nonrestorative, if the policy provides coverage for therapeutic care; and • Pharmacy care, if the policy covers prescription drugs. This coverage cannot be subject to financial requirements or treatment limitations that are more restrictive than the predominant financial requirements

MANDATE	DESCRIPTION
	and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.
Bone density screenings	Coverage for bone mineral density measurements or tests and, if a policy covers prescription drugs, drugs and devices approved by the federal Food and Drug Administration (FDA) or generic equivalents as approved substitutes.
Breast cancer surgery	Coverage for a period of inpatient hospital care determined by the attending physician in consultation with the patient to be medically appropriate for a person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the policy.
Breast reconstruction *New requirements effective Jan. 12, 2023*	Coverage for breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy, which must include all stages of reconstruction of the breast or chest wall on which the mastectomy or partial mastectomy was performed, and surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance. Chest wall surgery must include aesthetic flat closure as such term is defined by the National Cancer Institute.
Cervical cytology screenings	Coverage for an annual cervical cytology screening for cervical cancer and its precursor states for **women age 18 and older**.
Chiropractic care	Coverage for chiropractic care in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, where the interference is the result of or related to distortion, misalignment or subluxation of the vertebral column.
Colorectal cancer screenings *New mandate for 2023*	Large group policies must cover colorectal cancer preventive screenings in accordance with American Cancer Society Guidelines for colorectal cancer screening of average risk individuals, and upon the prescription of a health care provider. Coverage must also include additional colorectal cancer examinations and laboratory tests recommended in accordance with the Guidelines, including an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy performed as a result of a positive result on a non-colonoscopy preventive screening test. Large group policies must cover these screenings, examinations and laboratory tests upon any policy issuance or renewal that occurs six months after the date the Guideline is issued. This coverage cannot be subject to a deductible, coinsurance or any other cost-sharing requirements.

MANDATE	DESCRIPTION
Contraceptive services and methods	Coverage for the following services and contraceptive methods: • All FDA-approved contraceptive drugs, devices and other products (policies must allow for the dispensing of up to 12 months' worth of a contraceptive at one time); • Voluntary sterilization procedures; • Patient education and counseling on contraception; and • Follow-up services related to the drugs, devices, products and procedures covered under this mandate, such as management of side effects, counseling for continued adherence, and device insertion and removal. This coverage cannot be subject to deductibles, coinsurance, copayments or other cost-sharing requirements under the policy. Benefits for an employee under this mandate must be the same for a covered spouse or domestic partner and covered non-spouse dependents. This mandate includes all FDA-approved over-the-counter contraceptive drugs, devices and products as prescribed or as otherwise authorized under state or federal law. It also includes emergency contraception without cost-sharing when provided pursuant to a prescription or state law order or when lawfully provided over the counter. A religious employer's policy is not required to cover contraceptive methods that are contrary to the employer's religious beliefs; for these policies, enrollees have the option to purchase stand-alone contraceptive coverage.
COVID-19 immunizations and testing after May 11, 2023	After May 11, 2023, plans must still cover COVID-19 immunizations for children through the attainment of 19 years of age, and for adults under non-grandfathered plans. Plans cannot impose cost-sharing on in-network COVID-19 immunizations. Plans are not required to cover COVID-19 immunizations out-of-network unless the policy or contract otherwise provides such out-of-network coverage. After May 11, 2023, plans are not required to cover out-of-network COVID-19 diagnostic testing and related visits, unless otherwise covered under the policy, or unless one of the requirements for an out-of-network coverage exception is met. In addition, coverage for over-the-counter COVID-19 tests is not required, although issuers are strongly encouraged to continue to provide such coverage. Click here for more information.

MANDATE	DESCRIPTION
Diabetes equipment, supplies and education	Coverage for equipment, supplies and self-management education for the treatment of diabetes. While this coverage may be subject to annual deductibles and coinsurance consistent with those established for other benefits within a given policy, the total amount that a covered person is required to pay out of pocket for covered prescription insulin drugs cannot exceed **$100 per 30-day supply**—regardless of the amount or type of insulin needed to fill the prescription and regardless of the insured's deductible, copayment, coinsurance or any other cost-sharing requirement.
Dialysis treatment	Policies that only include coverage for in-network dialysis treatment cannot deny coverage of dialysis treatment provided by an out-of-network provider that is located outside of the issuer's service area if there is proper medical authorization and notice to the insurer. This coverage may be limited to **10 out-of-network visits** in a calendar year. This mandate does not require an insurer to reimburse the out-of-network provider at an amount greater than it would have paid for the same treatment within a network.
Emergency medical services	Coverage for services to treat an emergency condition provided in hospital facilities without the need for any prior authorization and regardless of whether the health care provider furnishing such services is a participating provider.
Enteral formulas	Policies that cover prescription drugs must include coverage for the cost of enteral formulas for home use (whether administered orally or via tube feeding) when a physician or other licensed health care provider legally authorized to prescribe medications has issued a written order. Coverage for certain inherited diseases of amino acid and organic acid metabolism (as well as severe protein allergic conditions) must include modified solid food products that are low protein, contain modified protein or are amino acid based that are medically necessary.
Eye drops	Policies that cover prescription drugs must include coverage for the limited refilling of eye drop medication requiring a prescription prior to the last day of the approved dosage period.
Health care forensic exams	Health care forensic examinations that are covered under the policy and performed pursuant to New York's public health law cannot be subject to annual deductibles or coinsurance.

MANDATE	DESCRIPTION
HIV prevention *New mandate for 2023*	Large group policies must cover the cost of pre-exposure prophylaxis (PrEP) for the prevention of HIV and post-exposure prophylaxis to prevent HIV infection. This coverage may be subject to annual deductibles and coinsurance consistent with those established for other benefits within a given policy, unless the PrEP or post-exposure prophylaxis has in effect a rating of "A" or "B" in the current recommendations of the U.S. preventive services task force.
Home health care	Coverage for at least **40 home health care visits** in any calendar year or continuous 12-month period for each covered person if hospitalization or confinement in a nursing facility would otherwise be required. This coverage must consist of: • Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse; • Part-time or intermittent home health aide services that consist primarily of caring for the patient; • Physical, occupational or speech therapy, if provided by the home health service or agency; and • Medical supplies, drugs and medications prescribed by a physician, and laboratory services provided by or on behalf of a certified or licensed home health agency.
Hospice care	Must make available and, if requested by the policyholder, provide coverage for hospice care. This coverage must include at least 210 days of inpatient hospice care in a hospice or in a hospital and home care and outpatient services provided by the hospice, including drugs and medical supplies. It must also include five visits for bereavement counseling services, either before or after the insured's death, provided to the family of the terminally ill insured.
Infertility	Cannot exclude coverage for hospital, surgical or medical care for the diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility. Coverage also cannot exclude: • Surgical or medical procedures which would correct malformation, disease or dysfunction resulting in infertility; and • Diagnostic tests and treatment procedures for infertility. Policies that provide prescription drug coverage must cover FDA-approved drugs for use in the diagnosis and treatment of infertility.

MANDATE	DESCRIPTION
	This coverage is NOT required to include the diagnosis and treatment of infertility in connection with certain procedures (except as provided below), including: (1) in vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; (2) the reversal of elective sterilizations; or (3) sex change procedures; (4) cloning; or (5) medical or surgical services or procedures that are deemed to be experimental. This coverage must include: • Standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility to an insured; and • For large group policies, three cycles of in-vitro fertilization used in the treatment of infertility. Insurers cannot discriminate based on an insured's expected length of life, present of predicted disability, degree of medical dependency, perceived quality of life, or other health conditions, nor based on personal characteristics, including age, sex, sexual orientation, marital status or gender identity.
Mammograms, screenings and diagnostic imaging for breast cancer detection	Coverage for mammography screening for occult breast cancer as follows: • Upon a physician's recommendation, a mammogram (which may include breast tomosynthesis) at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer; • A single baseline mammogram (which may include breast tomosynthesis) for covered persons age 35-39; and • An annual mammogram (which may include breast tomosynthesis) for covered persons age 40 and older. In addition, large group policies must cover an annual mammogram for covered persons age 35-39, upon the recommendation of a physician and subject to the insurer's determination that the mammogram is medically necessary. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds or magnetic resonance imaging, covered under the policy cannot be subject to annual deductibles or coinsurance.
Maternity care	Coverage for maternity care to the same extent that coverage is provided for illness or disease under the policy. Maternity coverage, other than coverage for perinatal complications, must include inpatient hospital coverage for mother and newborn for at least 48 hours after a vaginal childbirth and for at least 96 hours after a caesarean section. The

MANDATE	DESCRIPTION
	mother has the option to be discharged early and, in such cases, is entitled to at least one home care visit in addition to any other home health care coverage available under the policy. Maternity coverage must include the services of a licensed midwife whose practice meets certain requirements. It must also include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments.
Mental health services	Coverage for the diagnosis and treatment of mental health conditions at least equal to the policy's coverage for other health conditions.
Nursing home or skilled nursing facility care	Must make available, and if requested by the policyholder, provide coverage for care in a nursing home or a skilled nursing facility.
Obstetric and gynecological care	Policies that include coverage for obstetric/gynecological services cannot limit a female insured's direct access to primary and preventive obstetric/gynecologic services (including annual examinations, care resulting from such annual examinations and treatment of acute gynecologic conditions) from a qualified provider of her choice from within the plan or for any care related to a pregnancy. The qualified provider must discuss services and treatment plan with the insured's primary care practitioner in accordance with the requirements of the issuer, follow the issuer's policies and procedure and provide services pursuant to a treatment plan (if any) approved by the issuer.
Off-label cancer drug use	Policies that cover prescription drugs approved by the FDA for the treatment of certain types of cancer cannot exclude coverage of any drug on the basis that it has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA, provided the drug has been recognized for treatment of the specific type of cancer in certain medical reference compendia.
Oral cancer drugs	Policies that cover prescription drugs and cancer chemotherapy treatment must provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.
Ostomy supplies	Coverage for equipment and supplies used for the treatment of ostomies, if prescribed by a physician or other licensed health care provider.
Pasteurized donor human milk	Coverage for pasteurized donor human milk (which may include fortifiers as medically indicated) for inpatient use for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation

MANDATE	DESCRIPTION
	support. The infant must have a documented birth weight of less than 1,500 grams, or have a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
Preadmission testing	Coverage for preadmission tests performed in hospital facilities prior to scheduled surgery.
Pre-hospital emergency medical services	Coverage for pre-hospital emergency medical services for the treatment of an emergency condition when the services are provided by an ambulance service that has received a certificate to operate pursuant to the New York public health law.
Prescription drugs – opioids	Plans that provide coverage for prescription drugs subject to a copayment must charge a copayment for a limited initial prescription of an opioid drug prescribed in accordance with New York public health law that is either: • Proportional between the copayment for a 30-day supply and the amount of drugs the patient was prescribed; or • Equivalent to the copayment for a full 30-day supply of the opioid drug, provided that no additional copayments may be charged for any additional prescriptions for the remainder of the 30-day supply.
Prescription drugs – payments *New mandate for 2023*	Plans that provide coverage for a prescription drug must apply any third-party payments, financial assistance, discount, voucher or other price reduction instrument for out-of-pocket expenses made on behalf of an insured for the cost of prescription drugs to the insured's deductible, copayment, coinsurance, out-of-pocket maximum, or any other cost-sharing requirement when calculating the insured's overall contribution to any out-of-pocket maximum of any cost-sharing requirement. (Special rules apply to health savings account-qualified high deductible health plans.) This mandate only applies to a prescription drug that is either: • A brand-name drug with an AB rated generic equivalent, as determined by the FDA; or • A brand-name drug with an AB rated generic equivalent, as determined by the FDA, and the insured has access to the brand-name drug through prior authorization by the insurer or through the insurer's appeal process, including any step-therapy process; or • A generic drug the insurer will cover, with or without prior authorization or an appeal process.

MANDATE	DESCRIPTION
Preventive and primary care for children	Coverage for the following preventive and primary care services for a covered child from the date of birth through age 19: • An initial hospital check-up and well-child visits scheduled in accordance with the American Academy of Pediatrics; • At each visit, services in accordance with the American Academy of Pediatrics, including a medical history, complete physical examination, developmental assessment, anticipatory guidance, and laboratory tests; and • Necessary immunizations in accordance with the Advisory Committee on Immunization Practices.
Prostate cancer screenings	Coverage for diagnostic screening for prostate cancer as follows: • Standard diagnostic testing at any age for men having a prior history of prostate cancer; and • An annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. This coverage cannot be subject to the policy's annual deductible or coinsurance.
Second medical opinions for cancer diagnosis	Coverage for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.
Second surgical opinion	Coverage for a second surgical opinion by a qualified physician on the need for surgery.
Substance use services – inpatient care	Inpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. This coverage must include unlimited medically necessary treatment for substance use disorder treatment services provided in residential settings. Also, this coverage cannot be subject to any financial requirements or treatment limitations, including utilization review requirements, that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy.
Substance use disorder – treatment	Large group policies must provide coverage for prescription drugs for the treatment of a substance use disorder and cannot require prior authorization for an initial or renewal prescription for the detoxification or maintenance treatment of a substance use disorder, including all buprenorphine products, methadone,

MANDATE	DESCRIPTION
New requirements effective May 3, 2023	long acting injectable naltrexone, or medication for opioid overdose reversal prescribed or dispensed to an insured, including FDA-approved over-the-counter opioid overdose reversal medication as prescribed, dispensed or as otherwise authorized under state or federal law (except where otherwise prohibited by law). This coverage may be subject to copayments, coinsurance and annual deductibles that are consistent with those imposed on other benefits within the policy.
Substance use disorder – outpatient services	Outpatient coverage for the diagnosis and treatment of substance use disorder, including detoxification and rehabilitation services. This coverage cannot apply financial requirements or treatment limitations to outpatient substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. In addition, policies must provide up to 20 outpatient visits per year to an individual who identifies him or herself as a family member of a person suffering from substance use disorder and who seeks treatment as a family member who is otherwise covered by the applicable policy. A large group policy cannot impose copayments or coinsurance for outpatient substance use disorder services that exceed those imposed for a primary care office visit.

Provider Mandates

MANDATE	DESCRIPTION
Audiologist	If a policy covers any audiology service within the lawful scope of practice of a licensed audiologist, benefits must be provided for the service whether it is performed by a physician or a licensed audiologist. Nondiscrimination mandate.
Chiropractor	If a policy covers any service within the scope of practice of a licensed chiropractor, benefits must be provided for the service when it is performed by a licensed chiropractor. Nondiscrimination mandate.
Choice of health care provider	An issuer that requires or provides for designation by an insured of a participating primary care provider must permit the insured to designate any participating primary care provider who is available to accept the insured. In the case of a child, the issuer must permit the insured to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the issuer's network.

MANDATE	DESCRIPTION
Clinical social worker, mental health counselor, marriage and family therapist, psychoanalyst	If a policy provides reimbursement for psychiatric o psychological services or for the diagnosis and treatment of mental health conditions (however defined in the policy) by physicians, psychiatrists or psychologists, the issuer must provide the same coverage for these services when performed by a licensed clinical social worker, mental health counselor, marriage and family therapist, or psychoanalyst, within the lawful scopes of their practices.
Comprehensive care centers for eating disorders	Cannot deny benefits for services covered under a policy because they are provided by a comprehensive care center for eating disorders pursuant to the New York Public Health Law. Nondiscrimination mandate.
Dentist	If a policy provides for reimbursement for any dental service within the lawful scope of practice of a licensed dentist, benefits must be provided for the service whether it is performed by a physician or a licensed dentist. Nondiscrimination mandate.
Midwife	Under the maternity benefit mandate, coverage must be provided for the services of a licensed midwife who is practicing consistent with a collaborative relationship with a physician or hospital and who satisfies certain additional requirements.
Occupational therapist	If a policy covers any occupational therapy service within the lawful scope of practice of a licensed occupational therapist, benefits must be provided for the service whether it is performed by a physician or a licensed occupational therapist pursuant to prescription or referral by a physician. Nondiscrimination mandate.
Optometrist	If a policy covers any optometric service within the lawful scope of practice of a licensed optometrist, benefits must be provided for the service whether it is performed by a physician or a licensed optometrist. Nondiscrimination mandate.
Physical therapist	If a policy covers any physical therapy service within the lawful scope of practice of a licensed physical therapist, benefits must be provided for the service whether it is performed by a physician or a licensed physical therapist pursuant to prescription or referral by a physician. Nondiscrimination mandate.
Podiatrist	If a policy covers any service within the lawful scope of practice of a licensed podiatrist, benefits must be provided for the service whether it is performed by a physician or a licensed podiatrist. Nondiscrimination mandate.

MANDATE	DESCRIPTION
Psychologist	If a policy covers psychiatric or psychological services or the diagnosis and treatment of mental, nervous or emotional disorders, benefits must be provided for the services, diagnosis or treatment whether performed by a physician, psychiatrist or a certified and registered psychologist when the services rendered are within the lawful scope of the provider's practice. Nondiscrimination mandate.
Registered nurse first assistant	If a policy covers non-physician surgical first assistant services when services are provided by a non-physician surgical first assistant, the policy must cover these services when they are performed by a registered nurse first assistant provided that: (1) the registered nurse first assistant is certified in operating room nursing, (2) the services are within the scope of practice of a non-physician surgical first assistant, and (3) the terms and conditions of the policy otherwise provide for the coverage of the services.
Registered professional nurse	If a policy provides coverage for any service within the lawful scope of practice of a duly licensed registered professional nurse, an issuer must make available, and if requested by the contract holder, provide reimbursement for the service when it is performed by a duly licensed registered professional nurse. Nondiscrimination mandate.
Retail network pharmacies	Policies that provide coverage for prescription drugs must permit insured individuals to fill a covered prescription that may be obtained at a network participating mail-order pharmacy (or other non-retail pharmacy) at a network participating non-mail order retail pharmacy. The retail pharmacy must agree to the same reimbursement amount that the issuer has established for the mail-order pharmacy.
Speech language pathologist	If a policy provides coverage for any speech language pathology service within the lawful scope of practice of a duly licensed speech language pathologist, benefits must be provided for the service whether it is provided by a physician or by a licensed speech language pathologist. Nondiscrimination mandate.
Telehealth provider	Cannot exclude from coverage a service that is otherwise covered under the policy because the service is delivered via telehealth. Nondiscrimination mandate.

Person Mandates

MANDATE	DESCRIPTION
Continuation coverage	Must offer continuation coverage to employees, spouses and dependent children who would otherwise lose coverage due to a qualifying event. Qualifying events include: the employee's termination of employment or membership in the class or classes eligible for coverage; the employee's death; the divorce or legal separation of the employee from his or her spouse; the employee becoming entitled to benefits under Medicare; or a dependent child's loss of eligibility under the terms of the plan. The maximum continuation period is 36 months. State continuation coverage does not apply to individuals who are eligible to continue coverage under federal COBRA for 36 months.
Dependent coverage – age 26	Policies that provide coverage for children must provide this coverage to a child until age 26, without regard to marital status, financial dependence, residency with the employee or member, student status or employment.
Dependent coverage – age 30	Issuers must make available and, if requested by the policyholder, extend coverage under a policy to an eligible unmarried child through age 29 without regard to financial dependence. To be eligible for this coverage, the unmarried child: (1) must live, work or reside in New York or the insurer's service area; and (2) cannot be eligible for coverage under any employer health benefit plan as an employee or member.
Dependent coverage – medical leave of absence	Policies that provide coverage for dependent children past age 26 who are full-time students must continue the coverage of a dependent student who takes a leave of absence from school due to illness. This coverage must continue for a period of 12 months from the last day of attendance in school, or if earlier, until the age coverage would otherwise terminate under the policy.
Disabled dependent	Policies that provide dependent coverage must provide coverage for unmarried dependent children, regardless of age, who are incapable of self-sustaining employment by reason of mental illness, developmental disability, or physical handicap and who are chiefly dependent upon the employee or member for support and maintenance. To qualify for this extended coverage, a child must have become disabled prior to attaining the policy's limiting age.

MANDATE	DESCRIPTION
Newborns	Policies providing family coverage must provide that coverage of newborns is effective from the moment of birth for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including premature birth. This mandate also applies to newborn infants adopted by the insured if the insured takes physical custody of the infant upon such infant's release from the hospital and certain procedure requirements are satisfied.

**While many of the mandates described in the above chart are applicable to managed care plans, such as health maintenance organizations (HMOs), managed care plans may be subject to additional requirements under New York statutes and regulations that are not specifically addressed in the above chart. In addition, the chart focuses on mandates applicable to health insurance plans sponsored by private employers, and does not address mandates specifically applicable to the health benefits provided by government employers*.