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.
- **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 example, the Affordable Care Act (ACA) requires non-grandfathered health plans in the small group and individual markets to provide coverage for certain 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 charts outlining Texas's benefit, provider and person mandates for **group health insurance plans** (referred to as "**plans**" in this document). Please keep in mind that the charts do **not** address federal benefit mandates, such as the ACA's mandates.

State Resources

- Texas Department of Insurance (TDI) website
- The TDI provides information about mental health and substance abuse parity requirements here
- Texas statutes, including the Insurance Code, are available here

Benefit Mandates

MANDATE	DESCRIPTION
Acquired brain injury	Plans must cover treatment of an acquired brain injury, subject to the same payment limitations and cost-sharing factors as those that apply to other similar coverage. This coverage must include benefits for cognitive rehabilitation and communication therapy, neurofeedback therapy, post-acute transition services and community reintegration services.
Alzheimer's disease	Plans that cover Alzheimer's disease and require demonstrable proof of organic disease or other proof before authorizing payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a licensed physician, including a history, physical, neurological and psychological or psychiatric evaluations and laboratory studies.
Amino acid-based elemental formulas	Plans must cover medically necessary amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of: • Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; • Severe food protein-induced enterocolitis syndrome; • Eosinophilic disorders, as evidenced by the results of a biopsy; and • Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract. This coverage must include benefits for any medically necessary services associated with the administration of the formula. This coverage must also be: • No less favorable than a plan's coverage for prescription drugs and other medications and related services; and • Provided to the same extent as a plan's coverage for drugs that are available only on the orders of a physician.
Autism spectrum disorder	Plans must cover autism spectrum disorder screenings for children at the ages of **18 and 24 months**. Plans must also provide coverage for the treatment of autism spectrum disorder to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis, only if the diagnosis was in place **prior to the child's 10th birthday**. This coverage must include the following prescribed services (in accordance with the treatment plan recommended by the enrollee's physician): • Evaluation and assessment services; • Applied behavior analysis;

MANDATE	DESCRIPTION
	• Behavior training and behavior management; • Speech therapy; • Occupational therapy; • Physical therapy; and • Medications or nutritional supplements used to address symptoms of autism spectrum disorder. Benefits for applied behavior analysis for an enrollee who is **10 years of age or older** may be limited to **$36,000 per year**.
Biomarker testing	When use of biomarker testing provides clinical utility, plans delivered, issued or renewed on or after **Jan. 1, 2024**, must cover biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment when the test is supported by certain medical and scientific evidence. Coverage must be provided in a manner that limits disruptions in care, including limiting the number of biopsies and biospecimen samples.
Breast cancer surgery – inpatient care	Plans that cover breast cancer treatment must cover inpatient care for a minimum of: • **48 hours** following a mastectomy; and • **24 hours** following a lymph node dissection for the treatment of breast cancer. This length of inpatient care is not required if an insured and his or her attending physician determine that a shorter period is appropriate. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.
Cancer clinical trials – routine patient care	Plans must cover routine patient care costs incurred in connection with a phase I, phase II, phase III or phase IV clinical trial, if the clinical trial receives appropriate approval and relates to prevention, detection or treatment of a life-threatening disease or condition. This coverage may be subject to cost-sharing requirements comparable to those that apply to other benefits under a plan.
Cancer treatments – orally-administered anti-cancer drugs	Plans that cover cancer treatment must cover a prescribed, orally-administered anti-cancer medication that is used to kill or slow the growth of cancerous cells. This coverage must be no less favorable than a plan's coverage for intravenously administered or injected cancer medications. The cost to an insured for an orally-administered drug may not exceed the coinsurance or copayment that would be applied to a chemotherapy or other cancer treatment visit.

MANDATE	DESCRIPTION
Cardiovascular disease – early detection tests	Plans that cover screening medical procedures must cover up to **$200** for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function **every five years**: • Computed tomography (CT) scanning measuring coronary artery calcification; or • Ultrasonography measuring carotid intima-media thickness and plaque. This coverage must be provided to males between the **ages of 46 and 75** and females between the **ages of 56 and 75** who are diabetic or at risk of developing coronary heart disease.
Cervical and ovarian cancer screenings	Plans that cover diagnostic medical procedures must cover an annual examination for the early detection of cervical and ovarian cancer for women **age 18 or older**.
Chemical dependency treatment	Plans must cover necessary care and treatment of chemical dependency. This coverage may be limited to a lifetime maximum of **three separate treatment series** for each insured. Coverage for treatment in a chemical dependency treatment center must be the same as if the care and treatment were provided in a hospital. This coverage may **not** be less favorable than a plan's coverage for physical illness in general, except to the extent that different dollar or durational limits are sufficient to provide appropriate care and treatment under guidelines issued by the Texas Department of Insurance.
Childhood immunizations	Plans that provide family coverage must cover immunizations for each covered child from **birth through age 6**, without any cost-sharing requirements. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.
Colon cancer screenings	Plans that cover screening medical procedures must cover colon cancer screenings for enrolled individuals who are **age 45 or older** and at normal risk for developing colon cancer. This coverage must include benefits for: • All colorectal cancer examinations, preventive services and laboratory tests assigned a grade of "A" or "B" by the U.S. Preventive Services Task Force for average-risk individuals (including the services that may be assigned a grade "A" or "B" in the future); and • An initial colonoscopy or other medical test or procedure for colorectal cancer screening, and a follow-up colonoscopy if the results of the initial colonoscopy, test or procedure are abnormal.
Contraceptive coverage	Plans that cover prescription drugs or devices must also cover to the same extent:

MANDATE	DESCRIPTION
	• Prescription contraceptive drugs or devices approved by the U.S. Food and Drug Administration (FDA); and • Outpatient contraceptive services. This mandate does **not** require plans to cover any drug or device that terminates a pregnancy. An exception to this mandate is available for religious employers, except when a prescription contraceptive is necessary to preserve the life or health of an insured. In addition, plans delivered, issued or renewed on or after **Jan. 1, 2024**, that provide benefits for a prescription contraceptive drug must provide for an enrollee to obtain up to: • A three-month supply of the covered prescription contraceptive drug at one time the first time the enrollee obtains the drug; and • A 12-month supply of the covered prescription contraceptive drug at one time each subsequent time the enrollee obtains the same drug, regardless of whether the enrollee was enrolled in the plan the first time the enrollee obtained the drug.
Craniofacial abnormalities - children	Plans that provide family coverage must cover reconstructive surgery for craniofacial abnormalities and must define this term as surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease for a child who is younger than **18 years of age**. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.
Development delays – children	Plans must offer to cover the following for a child: • Occupational therapy evaluations and services; • Physical therapy evaluations and services; • Speech therapy evaluations and services; and • Dietary or nutritional evaluations. These therapies may not be applied to a plan's annual or lifetime maximum benefit. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.
Diabetes	Plans must cover diabetes equipment, supplies and self-management training, on the same basis as similar coverage under a plan. Plans must also cover emergency refills of diabetes equipment or supplies, in the same manner as for nonemergency refills of diabetes equipment or supplies. Covered equipment and supplies must include:

MANDATE	DESCRIPTION
	• Blood glucose monitors, including those designed to be used by or adapted for the legally blind; • Test strips specified for use with a corresponding glucose monitor; • Lancets and lancet devices; • Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; • Insulin and insulin analog preparations; • Injection aids, including devices used to assist with insulin injection and needleless systems; • Insulin syringes; • Biohazard disposal containers; and • Insulin pumps, both external and implantable, and associated appurtenances. Diabetes self-management training must be covered when: • Diabetes is initially diagnosed; • A significant change in the symptoms or condition of the insured requires changes in the insured's self-management regime; or • Periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**. Additional mandates apply to prescription insulin (see "prescription drug" mandates below).
Emergency care	Plans must cover emergency health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility. Benefits for out-of-network emergency services may not be subject to different cost-sharing requirements than those that apply to in-network services if: • A medical screening examination or other evaluation required by state or federal law is needed to determine whether a medical emergency condition exists; • The services are necessary to treat and stabilize an emergency medical condition; or • The services originated in an emergency facility following treatment or stabilization of an emergency medical condition. In addition, for emergency medical services provided on or after **Jan. 1, 2024**, plans must reimburse ground ambulance services at: a rate set, controlled or regulated by a political subdivision if the entity has submitted the rate to the TDI database (with annual increases for inflation), or the lesser of the billed charge or 325% of Medicare.

MANDATE	DESCRIPTION
Fertility preservation services	Plans delivered, issued or renewed on or after **Jan. 1, 2024**, must cover fertility preservation services to a covered person who will receive a medically necessary treatment for cancer (including surgery, chemotherapy or radiation), that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility. The services must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines.
Fertility treatment – in vitro fertilization	Plans that include pregnancy-related benefits must offer to cover in vitro fertilization procedures to the same extent as other pregnancy-related procedures. This coverage may be limited to circumstances under which: • The fertilization or attempted fertilization of a patient's oocytes is made only with the sperm of the patient's spouse; • The patient and the patient's spouse have a history of infertility for at least five continuous years or the patient's infertility is associated with endometriosis, exposure in utero to diethylstilbestrol (DES), blockage of or surgical removal of one or both fallopian tubes or oligospermia; • The patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which plan coverage is available; and • The in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards adopted by the American Society for Reproductive Medicine. An exception to this mandate is available for certain religious employers.
Hearing aids and cochlear implants for children	Plans must cover the cost of a medically necessary hearing aid or cochlear implant and related services and supplies for a covered individual who is **18 years of age or younger**. This coverage must include: • Fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids; • Any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and • For a cochlear implant, an external speech processor and controller with necessary components replacement every three years. This coverage can be limited to **one hearing aid in each ear every three years** and **one cochlear implant in each ear with internal replacement as medically or audiologically necessary.**
Hearing aids – choice	Plans delivered, issued or renewed on or after **Jan. 1, 2024**, that provide coverage for hearing aids may not deny an enrollee's claim for a hearing aid

MANDATE	DESCRIPTION
	solely on the basis that the price of the hearing aid is more than the benefit available under the plan.
Hearing tests for children	Plans that provide family coverage must include coverage, without cost-sharing, for the following: • A screening test for hearing loss from **birth to 30 days of age**; and • Necessary diagnostic follow-up care related to the screening test from **birth to 24 months of age**. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.
HIV, AIDS or HIV-related illnesses	Plans must cover treatment and care of human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) or an HIV-related illness.
Home health care	Plans must offer to cover home health services provided by a home health agency on the same basis as a plan's coverage for hospital services. This coverage may be subject to: • A limit of 60 or more visits per year; • An exclusion for custodial care; • An exclusion for services provided by an individual who resides in the insured's home or is a member of the insured's family; and • Services provided to an insured who is eligible for Medicare coverage.
Mammograms	Plans must cover annual breast cancer screenings, to the same extent as a plan's coverage for other radiological examinations, for insured women who are **35 years of age or older**. Plans that provide coverage for a screening mammogram must also cover diagnostic imaging that is no less favorable than the coverage for a screening mammogram.
Mastectomy – reconstructive surgery	Plans that cover mastectomy must also cover the following, consistent with other coverage and without dollar limits other than the lifetime maximum benefits under a plan: • Reconstruction of the breast on which the mastectomy has been performed; • Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and • Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.
Maternity – inpatient stay and post-delivery care	Plans that include maternity and childbirth benefits must cover inpatient care in a health care facility for a woman and her newborn child for at least: • **48 hours** after an uncomplicated vaginal delivery; and

MANDATE	DESCRIPTION
	• **96 hours** after an uncomplicated delivery by cesarean section. If a woman or her newborn child are discharged from inpatient care earlier, a plan must cover timely post-delivery care.
Medically necessary foods and formulas	Plans must cover formulas necessary to treat **phenylketonuria** or a **heritable disease** to the same extent as any covered drugs that are available only on the orders of a physician.
Mental health – alternative treatment benefits	Plans that cover hospital treatment of mental or emotional illness or disorder must also cover treatment in a **residential treatment center for children and adolescents** or a **crisis stabilization unit** to the same extent as a plan's coverage for inpatient psychiatric treatment. For purposes of determining plan benefits and maximums, each two days of treatment in a residential treatment center or in a crisis stabilization unit is the equivalent of one day in a hospital or inpatient program.
Mental health – psychiatric day treatment facility	Plans must offer to cover treatment of mental or emotional illness or disorder when in a hospital or psychiatric day treatment facility. The psychiatric day treatment facility coverage may not be less favorable than the hospital coverage and must be subject to the same durational limits, deductibles, and coinsurance factors.
Mental health – serious mental illness	Plans sponsored by **employers with 51 or more employees** must cover (and small-employer plans must offer to cover) a minimum of the following treatments for **serious mental illness** in each calendar year, to the same extent as a plan's coverage for physical illness: • **45 days** of inpatient treatment; and • **60 visits** for outpatient treatment, including group and individual outpatient treatment. This coverage may not be subject to a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment. This mandate does **not** require coverage for treatment of: • Addiction to a controlled substance or marijuana used in violation of law; or • Mental illness resulting from the use of a controlled substance or marijuana in violation of law. Plans delivered, issued or renewed on or after **Jan. 1, 2024**, providing coverage for prescription drugs to treat serious mental illness may not require, before providing coverage of an FDA-approved prescribed drug, that the enrollee fail to successfully respond to more than one different drug for each drug prescribed or prove a history of failure of more than one

MANDATE	DESCRIPTION
	different drug for each prescribed (excluding generic or pharmaceutical equivalents). Specific step therapy protocols must also be followed.
Mental health conditions and substance use disorders – parity requirements	Plans must provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage. This coverage may not impose quantitative or nonquantitative treatment limitations on benefits for a mental health condition or substance use disorder that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.
Osteoporosis	Plans must cover medically accepted bone mass measurements to detect low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis for qualified enrollees. Qualified enrollees include: • A postmenopausal woman who is not receiving estrogen replacement therapy; • An individual with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or • An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
Prescription drugs	Plans that cover drugs must cover any drug prescribed to treat an insured for a chronic, disabling or life-threatening illness covered under a plan. This mandate applies only for drugs that are: • FDA-approved for at least one indication; and • Recognized by certain medical compendium or literature for treatment of the condition for which the drug is prescribed. This coverage must also include medically necessary services associated with the administration of the drug. Plans may not deny this coverage based on a "medical necessity" requirement unless the reason for the denial is unrelated to the legal status of the drug use. This mandate does **not r**equire a plan to cover: • Experimental drugs that are not FDA-approved; • Any disease or condition that is excluded from coverage under the plan; or • A drug that the FDA has determined to be contraindicated for treatment of the current indication. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.

MANDATE	DESCRIPTION
Prescription drugs – copay accumulators	Plans delivered, issued or renewed on or after **Jan. 1, 2024**, that cover prescription drugs must apply any third-party payment for prescription drugs to the enrollee's deductible, copayment, cost-sharing responsibility, or out-of-pocket maximum applicable to health benefits under the enrollee's plan.
Prescription drugs – cost-sharing limits and formulary requirement for insulin	Plans may not impose a cost-sharing provision for insulin that is included in the plan's formulary if the total amount the enrollee is required to pay **exceeds $25 per prescription for a 30-day supply**, regardless of the amount or type of insulin needed to fill the prescription. For this purpose, "insulin" means a prescription drug that contains insulin and is used to treat diabetes. The term does not include an insulin drug that is administered to a patient intravenously. Plans must also include at least one insulin from each therapeutic class in the plan's formulary.
Prescription drugs – multiple prior authorizations prohibition	Plans delivered, issued or renewed on or after **Jan. 1, 2024**, that provide prescription drug benefits cannot require an enrollee to receive more than one prior authorization annually of the prescription drug benefit for a drug prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease. Certain exceptions apply.
Prescription drugs – payments and eye drop refills	Plans that cover prescription drugs may not require an enrollee to make a payment for a prescription drug at the point of sale in an amount greater than the lesser of: • The applicable copayment; • The allowable claim amount for the prescription drug; or • The amount an individual would pay for the drug if the individual purchased the drug without using a health benefit plan or any other source of drug benefits or discounts. Plans that cover prescription eye drops to treat a chronic eye disease or condition must allow the **refill of prescription eye drops** if the enrollee timely pays at the point of sale the maximum amount allowed (described above) and: • The original prescription states that additional quantities of the eye drops are needed; • The refill does not exceed the total quantity of dosage units authorized by the prescribing provider on the original prescription, including refills; and • The refill is dispensed on or before the last day of the prescribed dosage period and not earlier than specific statutory timeframes.
Prescription drugs – proration of cost-sharing for partial supply	Plans that cover prescription drugs must prorate any cost-sharing amount charged for a partial supply of a prescription drug if:

MANDATE	DESCRIPTION
	• The pharmacy (or the enrollee's prescribing physician or health care provider) notifies the plan that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the enrollee's prescription drugs and the synchronization is in the best interest of the enrollee; and • The enrollee agrees to the synchronization.
Prescription drugs – stage-four advanced, metastatic cancer	Plans that cover stage-four advanced, metastatic cancer and associated conditions may not require, before the plan covers an FDA-approved prescription drug, that the enrollee: • Fail to successfully respond to a different drug; or • Prove a history of failure of a different drug.
Prescription drugs – step therapy protocols	Plans that require a step therapy protocol before providing coverage for a prescription drug must establish, implement and administer the step therapy protocol in accordance with clinical review criteria readily available to the health care industry. In addition, plans must establish a process in a user-friendly format that is readily accessible to a patient and prescribing provider through which an exception request to the step therapy protocol may be submitted by the provider.
Prescription drugs – synchronization plans	Plans must establish a process through which the following parties may jointly approve a medication synchronization plan for medication to treat an enrollee's chronic illness – the plan, the enrollee, the prescribing physician or health care provider and a pharmacist. The plan must provide coverage for a medication dispensed according to the dates established in the approved medication synchronization plan.
Prostate cancer screenings	Plans that cover diagnostic medical procedures must cover an annual examination for the detection of prostate cancer, including a physical examination and a prostate-specific antigen test used for the detection of prostate cancer for each male who is at least: • **50 years of age** and is asymptomatic; or • **40 years of age** and has a family history of prostate cancer or another prostate cancer risk factor. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.
Prosthetics and orthotic devices	Plans must cover prosthetic devices, orthotic devices and professional services related to the fitting and use of those devices on a basis equivalent to the coverage provided under the Medicare program. This coverage may **not** be subject to annual dollar limits.

MANDATE	DESCRIPTION
Speech or hearing – loss or impairment	Plans must offer to cover necessary care and treatment of loss or impairment of speech or hearing on the same basis as covered physical illness in general.
Telemedicine/teledentistry/telehealth	Plans must provide coverage for a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service, teledentistry dental service, or telehealth service on the same basis and to the same extent that the plan provides coverage for the service or procedure in an in-person setting. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.
Temporomandibular joint (TMJ)	Plans that cover medically necessary diagnostic and surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint (TMJ), if the treatment is medically necessary as a result of: • An accident or trauma; • A congenital defect; • A developmental defect; or • A pathology. This coverage may be subject to any provision plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage. This mandate does **not** require coverage for dental services if dental services are not otherwise scheduled or provided as part of the plan's coverage. This mandate does **not** apply to plans sponsored by employers with **50 or fewer employees**.

Provider Mandates

MANDATE		DESCRIPTION
Acupuncturist	**Occupational therapist**	Nondiscrimination mandates: If a plan covers services within the scope of these providers' licenses and practices, the plan must cover the services when performed by these providers within their scopes.
Advanced practice nurse	**Optometrist**	
Audiologist	**Physical therapist**	
Chemical dependency counselor	**Physician assistant**	
Clinical social worker	**Podiatrist**	

MANDATE		DESCRIPTION
Chiropractor	Professional counselor	
Dentist	Psychological associate	
Dietician	Psychologist	
Hearing instrument fitter and dispenser	Speech-language pathologist	
Marriage and family therapist	Surgical assistant	
Nurse first assistant		Nondiscrimination mandate: An insured may select a nurse first assistant to provide the services scheduled in a plan that are within the scope of the nurse's license and requested by the physician whom the nurse is assisting.
Pharmacist		An insured may select a pharmacist to provide covered services that are within the scope of the pharmacist's license to practice pharmacy.

Person Mandates

MANDATE	DESCRIPTION
Adopted children	Plans that provide family coverage may not exclude or limit coverage of a child solely because the child is adopted.
Child of spouse	Plans that provide family coverage may not exclude or limit coverage of a child solely because the child is the natural or adopted child of the insured's spouse.
Continuation coverage	Plans must offer continuation coverage to insured employees and dependents if: • Coverage would otherwise be terminated for any reason other than the employee's involuntary termination for cause; and • The individual has been continuously insured under the plan for at least **three consecutive months** before termination. The maximum continuation period is **nine months**, or, if the individual is eligible for federal COBRA coverage, **six additional months** following any period of COBRA coverage. If a family member or dependent's coverage would end because of severance of the family relationship or the insured employee's retirement or death, the continuation coverage may be elected for a maximum period of **three years** as long as the family member or dependent has been insured under the plan for a least **one year** or is an infant under one year of age.

MANDATE	DESCRIPTION
Dependent - adult child coverage	Plans that provide family coverage must cover: • An unmarried child who is younger than **25 years** of age; and • A child who is a full-time student, younger than 25 years of age and financially dependent on the parent.
Dependent – disability extension	Plans that have an age limit for dependent coverage must provide that a child's attainment of that age does not terminate coverage while the child is: • Incapable of self-sustaining employment because of intellectual or physical disability; and • Chiefly dependent on the insured for support and maintenance.
Grandchildren	Plans that provides family coverage must cover a grandchild of an insured if the grandchild is: • Unmarried; • Younger than **age 25**; and • A dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made. Coverage for a grandchild may not be terminated solely because the covered grandchild is no longer a dependent of the insured for federal income tax purposes.
Newborns	Plans that provide maternity benefits (or accident and health coverage for additional newborn children) may not exclude or limit: • Initial coverage of a newborn child for a period of time; • Coverage for congenital defects of a newborn child; or • Coverage for administration of the newborn screening tests required by state law.