STATE EMPLOYMENT LAWS

Health insurance mandates differ from state to state and often contain detailed criteria. This chart provides a general overview of health insurance mandates and is provided to you for general informational purposes only. It summarizes mandates contained in state statutes, but does not include references to other legal resources (such as supporting regulations, or formal or informal opinions of state departments of insurance), unless specifically noted. Please seek qualified and appropriate counsel for further information and/or advice regarding the application of health insurance mandates to your employee benefits plans.

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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 treatments, services or procedures to employers for purchase.
- **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, effective for plan years beginning on or after Jan. 1, 2014, 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.

California has a divided legal and regulatory system for health insurance plans. The Department of Managed Health Care (DMHC) regulates **health care service plans**, which include managed care plans such as health maintenance organizations (HMOs) and certain preferred provider organizations (PPOs). The California Department of Insurance (CDI) regulates **health insurance policies**.

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

BENEFIT MANDATE	DESCRIPTION
Acupuncture	Health insurance policies must offer coverage for expenses incurred as a result of treatment by acupuncturists. Mandate to offer coverage also applies to health care service plans, except health maintenance organizations (HMOs).
Alcoholism Treatment	Health insurance policies and health care service plans must offer coverage for the treatment of alcoholism.
Asthma Management (Pediatric)	Health care service plans that cover outpatient prescription drugs must include coverage for the following when medically necessary for the management and treatment of pediatric asthma: • Inhaler spacers;

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	• Nebulizers, including face masks and tubing; and • Peak flow meters. Education for pediatric asthma must be consistent with current professional medical practice. These pediatric asthma benefits must be provided under the same general terms and conditions, including copayments and deductibles, applicable to all other benefits provided by the plan.
Behavioral Health Treatment for Autism and Related Disorders (Effective July 1, 2012)	Health insurance policies and health care service plans must provide coverage for behavioral health treatment for pervasive developmental disorder or autism. "Behavioral health treatment" means professional services and treatment programs (including **applied behavior analysis** and **evidence-based behavior intervention programs**) that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria: • The treatment is prescribed by a licensed physician or is developed by a licensed psychologist; • The treatment is provided under a treatment plan prescribed by a qualified autism service provider; • The treatment is administered by a qualified autism service provider or by a qualified autism service professional or paraprofessional who is employed and supervised by the qualified autism service provider; • The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated; and • The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care or educational services and is not used to reimburse a parent for participating in the treatment program. These benefits may be subject to case management, network providers, utilization review techniques, prior authorization, copayments or other cost sharing. Insurers and plans subject to this mandate must maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. A "qualified autism service provider" means either of the following: • A person, entity or group that is certified by a national entity (such as the Behavior Analyst Certification Board), that is accredited by the National Commission for Certifying Agencies, and that designs, supervises or provides treatment for pervasive developmental disorder or autism; or • A person licensed as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist or audiologist who designs, supervises or provides treatment for pervasive developmental disorder or autism.

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	This mandate will expire on Jan. 1, 2017, unless a law is enacted before then to extend this mandate.
Blood Lead Levels Screening for Children	Health insurance policies and health care service plans must offer coverage for blood lead level screening for children.
Breast Cancer – Screening, Diagnosis and Treatment	Health insurance policies and health care service plans must provide coverage for breast cancer screening, diagnosis and treatment. Breast cancer screening and diagnosis must be covered consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's or enrollee's physician. Breast cancer treatment includes coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery must be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.
Cancer Clinical Trials – Routine Patient Care	Health insurance policies and health care service plans must provide coverage for all routine patient care costs for an insured or enrollee diagnosed with cancer and accepted into a phase I, phase II, phase III or phase IV clinical trial for cancer, if the treating physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the insured or enrollee. Copayments and deductibles must be consistent with those applied to the same services when they are not delivered in a clinical trial.
Cancer Screening Tests	Health insurance policies and health service plans must provide coverage for all generally medically accepted cancer screening tests.
Cervical Cancer Screening	Health insurance policies and health care service plans that include coverage for treatment or surgery of cervical cancer must provide coverage for an annual cervical cancer screening test. This coverage includes the conventional Pap test, a human papillomavirus screening test that is approved by the federal Food and Drug Administration (FDA) and the option of any cervical cancer screening test approved by the federal FDA, upon the referral of the patient's health care provider.
Contraceptive Coverage	Health insurance policies and health care service plans that provide coverage for outpatient prescription drugs must include coverage for a variety of federal FDA-approved prescription contraceptive methods, under the same terms and conditions as applicable to all benefits. There is an exception for religious employers.
Diabetes	Health insurance policies and health care service plans must include coverage for the following **equipment and supplies** for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and gestational diabetes as medically necessary, even if the items are available without a prescription: • Blood glucose monitors and blood glucose testing strips; • Blood glucose monitors designed to assist the visually impaired; • Insulin pumps and all related necessary supplies; • Ketone urine testing strips;

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	• Lancets and lancet puncture devices; • Pen delivery systems for the administration of insulin; • Podiatric devices to prevent or treat diabetes-related complications; • Insulin syringes; and • Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin. Health insurance policies and health care service plans that cover prescription benefits must include coverage for the following medically necessary prescription items: • Insulin; • Prescriptive medications for the treatment of diabetes; and • Glucagon. The coinsurances and deductibles for these benefits cannot exceed those established for similar benefits under the policy. Health insurance policies and health care service plans must provide coverage for diabetes **outpatient self-management training, education and medical nutrition therapy** necessary to enable an insured to properly use the diabetes equipment, supplies and medications. The coinsurances and deductibles may not exceed those established for physician office visits. Health insurance issuers must also offer coverage for diabetic **daycare self-management education programs** (instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy).
Diethylstilbestrol	Health insurance policies and health care service plans cannot contain any exclusion, reduction or other limitations, as to coverage, deductibles or coinsurance provisions applicable solely to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.
Emergency Medical Transportation	Health insurance policies that provide coverage for emergency health care services must include coverage for ambulance services provided through the "911" emergency response system. A similar coverage mandate applies to health care service plans.
Foot Disfigurement – Special Footwear	Health insurance policies and health care service plans must offer coverage for special footwear needed by persons who suffer from foot disfigurement (such as disfigurement from cerebral palsy, arthritis, polio, spina bifida and diabetes and foot disfigurement caused by accident or developmental disability).
General Anesthesia and Facility Charges for Dental Procedures	Health insurance policies and health care service plans must cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. This coverage mandate applies to an insured or enrollee: • Who is under seven years of age; • Who is developmentally disabled, regardless of age; or

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	• Whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.
HIV/AIDS, AIDS Vaccine	Health insurance policies and health care service plans must provide coverage for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal FDA and is recommended by the United States Public Health Service.
HIV/AIDS, HIV Testing	Health insurance policies and health care service plans must provide coverage for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
HIV/AIDS, Transplantation Services	Health insurance policies and health care service plans cannot deny coverage that is otherwise available for the costs of solid organ or other tissue transplantation services because the insured or enrollee is HIV positive.
Home Health Care	Health insurance policies must offer benefits for home health care by a licensed home health agency. (In certain rural areas, the services of visiting nurses, if available, may be substituted for the services of a home health agency.) Home health services consist of the following: • Part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; • Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; • Physical, occupational or speech therapy; and • Medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the policy if the insured person had remained in the hospital. The number of covered home health visits cannot be less than 100 visits in any year for each person covered under the policy. Home health care benefits may be subject to an annual deductible of not more than $50 and coinsurance not less than 80 percent of the reasonable charges for the home health care services.
Hospice Care	Health care service plans must include a provision for hospice care. In general, the hospice care benefits must be at least equivalent to the hospice care provided under Medicare.
Infertility Treatments	Health insurance policies and health care service plans (except health maintenance organizations offering coverage to employers with less than 20 employees) must offer coverage for infertility treatment, except in vitro fertilization. Infertility treatments include procedures consistent with established medical practices in the treatment of infertility by licensed physicians, such as diagnosis, diagnostic tests, medication, surgery and gamete intrafallopian transfer. There is an exception for religious organizations. Effective Jan. 1, 2014, coverage for the treatment of infertility must be offered and, if purchased, provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender

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	expression, gender identity, genetic information, marital status, national origin, race, religion, sex or sexual orientation.
Intoxicants/Controlled Substances – Exclusion Prohibited	Health insurance policies may not contain a general exclusion for when the insured is intoxicated or under the influence of any controlled substance.
Jawbone or Associated Bone Joints	Health insurance policies must cover medically necessary surgical procedures for covered conditions that directly affect the upper or lower jawbone or associated bone joints. A similar coverage mandate applies to health service plans.
Mammograms	Health insurance policies must provide the following mammogram coverage (upon the referral of a nurse practitioner, certified nurse midwife, physician assistant or physician) for breast cancer screening or diagnostic purposes: • A baseline mammogram for women **ages 35 to 39**; • A mammogram for women **ages 40 to 49** every two years or more frequently based on a physician's recommendation; and • A mammogram every year for women **ages 50 and over**. A mammography coverage mandate also applies to health service plans.
Maternity Benefits	Health insurance policies and health care service plans that provide maternity coverage cannot: • Contain a copayment or deductible for inpatient hospital maternity services that exceeds the most common amount for other covered inpatient services; or • Contain a copayment or deductible for ambulatory care maternity services that exceeds the most common amount for ambulatory care services provided for other covered medical conditions. In addition, if a policy or plan has covered a person continuously from conception, it cannot contain any exclusion, reduction or other limitations as to coverage, deductibles or coinsurance provisions for involuntary complications of pregnancy, unless the provisions apply generally to all benefits paid under the policy or plan. Involuntary complications of pregnancy include: puerperal infection; eclampsia; cesarean section delivery; ectopic pregnancy; and toxemia. See below for the maternity benefit mandate for health insurance policies that becomes effective on July 1, 2012.
Maternity Benefits	Health insurance policies must provide coverage for maternity services for all insureds covered under the policy. "Maternity services" include: prenatal care; ambulatory care maternity services; involuntary complications of pregnancy; neonatal care; and inpatient hospital maternity care, such as labor and delivery and postpartum care. Also, the covered maternity services must be consistent with the scope of benefits under the ACA's maternity benefit requirement.
Maternity Benefits – Minimum Length of Stay	Health insurance policies and health care service plans that provide maternity coverage cannot restrict benefits for inpatient hospital care to a time period less than **48 hours** following a normal vaginal delivery and less than **96 hours** following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48

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	or 96 hours if: • The early discharge decision is made by the treating physician in consultation with the mother; and • A post-discharge follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician, is covered.
Maternity Benefits - Prenatal Diagnosis of Genetic Disorders	Health insurance policies and health care service plans that provide maternity benefits must offer coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy.
Maternity Benefits - Prenatal Testing Program (Expanded Alpha Feto Protein Program)	Health insurance policies and health service plans that provide maternity benefits must cover participation in the Expanded Alpha Feto Protein (AFP) program, which is a statewide prenatal testing program administered by the California Department of Health Services.
Mastectomy and Lymph Node Dissection	Health insurance policies and health service plans that provide coverage for mastectomies and lymph node dissections must: • Allow the length of hospital stay to be determined by the attending physician in consultation with the patient (post-surgery), consistent with sound clinical principles and processes; • Cover prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy; and • Cover all complications from a mastectomy, including lymphedema. Coverage for prosthetic devices and reconstructive surgery must be subject to the deductible and coinsurance conditions applicable to other benefits.
Mental and Nervous Disorders	Health insurance policies must offer coverage for mental or nervous disorders.
Mental Illness – Severe Mental Illness and Serious Emotional Disturbances of Children	Health insurance policies and health care service plans must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions. These benefits must include: outpatient services; inpatient hospital services; partial hospital services; and prescription drugs, if the policy or plan includes coverage for prescription drugs. The maximum lifetime benefits, copayments, coinsurance and deductibles for these benefits must be applied equally to all benefits under the policy or plan. "Severe mental illnesses" include: schizophrenia; schizoaffective disorder; bipolar disorder (manic-depressive illness); major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa. *The federal Mental Health Parity and Addiction Equity Act (MHPAEA) creates additional parity requirements for employers with more than 50 employees that offer mental health or substance use disorder benefits in their group health plans. Depending on a plan's design, the MHPAEA may require stricter parity requirements than state law mandates. Also, beginning in*

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	2014, the ACA requires non-grandfathered health plans in the individual and small group markets to cover mental health and substance use disorder services and comply with the federal parity law.
Orthotic and Prosthetic Devices and Services	Health insurance policies must offer coverage for orthotic and prosthetic devices and services, which must include original and replacement devices. The benefit amount cannot be less than the annual and lifetime benefit maximums applicable to all benefits in the policy. Any copayment, coinsurance, deductible and maximum out-of-pocket amount cannot be more than the most common amounts contained in the policy. A similar mandate applies to health care service plans.
Osteoporosis	Health insurance policies and health care service plans must include coverage for services related to diagnosis, treatment and appropriate management of osteoporosis. The services may include all federal FDA-approved technologies, including bone mass measurement technologies as deemed medically appropriate.
Pain Management Medication for Terminally Ill Patients	Health care service plans that cover prescription drug benefits must provide coverage for appropriately prescribed pain management medications for terminally ill patients when medically necessary.
Phenylketonuria (PKU)	Health insurance policies and health care service plans must provide coverage for the testing and treatment of phenylketonuria (PKU). PKU coverage must include formulas and special food products that are part of a diet prescribed by a licensed physician, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Benefits are payable only to the extent that the cost of necessary formulas and special food products exceeds the cost of a normal diet.
Prescription Drugs – Coverage for Drugs Approved Before July 1, 1999	Health care service plans that cover prescription drug benefits cannot limit or exclude coverage for a drug that was previously approved for coverage by the plan for an enrollee's medical condition if the plan's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.
Prescription Drugs – Off-Label Use	Health insurance policies and health care service plans that cover prescription drugs cannot limit or exclude coverage for the off-label use of a drug, provided the drug: • Is approved by the FDA; • Is prescribed for the treatment of a life-threatening condition or a chronic and seriously debilitating condition (provided the drug is medically necessary to treat that condition and the drug is on the insurer's formulary, if any); and • Has been recognized for treatment of that condition by the American Hospital Formulary Service's Drug Information or certain medical compendia.
Preventive Care for Children - Age 16 and Younger	Health insurance policies and health care service plans must provide benefits for the comprehensive preventive care of children **16 years of age or younger**. Covered benefits must include: • Periodic health evaluations;

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	• Immunizations; and • Laboratory services in connection with periodic health evaluations.
Preventive Care of Children - Age 17 or 18	Health insurance policies and health care service plans must offer benefits for the comprehensive preventive care of children **17 and 18 years of age.** Benefits must be offered for the following: • Periodic health evaluations; • Immunizations; and • Laboratory services in connection with periodic health evaluations.
Prostate Cancer – Screening and Diagnosis	Health insurance plans and health care service plans must cover the screening and diagnosis of prostate cancer, including prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice.
Prosthetic Devices for Laryngectomy	Health insurance policies and health care service plans that cover the surgical procedure known as a laryngectomy (removal of the larynx for medically necessary reasons) must include coverage for prosthetic devices to restore a method of speaking.
Reconstructive Surgery (Including Cleft Palate)	Health insurance policies and health care service plans must cover reconstructive surgery. "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It must be performed to either improve function or create a normal appearance, to the extent possible. This mandate does not cover cosmetic surgery. This mandate also includes coverage for medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate This mandate does not require coverage for cosmetic surgery, which is surgery performed to alter or reshape normal structures of the body to improve the patient's appearance.
Sterilization Rationale Exclusion	Health insurance policies and health care service plans that cover all or part of the cost of a sterilization operation or procedure cannot include any exclusion, reduction or limitation on this benefit based upon the covered person's reason for requesting sterilization.

PROVIDER MANDATE	DESCRIPTION
Acupuncturists	Health policy insurers must offer coverage for expenses incurred as a result of treatment by acupuncturists. Mandate to offer coverage also applies to health care service plans, except health maintenance organizations (HMOs). Acupuncturists are also subject to a nondiscrimination mandate, to the extent a policy or plan covers acupuncture. A **nondiscrimination mandate** requires coverage if the health policy or plan reimburses services within the scope of the health care professional's

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	practice.
Advanced Practice Registered Nurse	Nondiscrimination mandate. To be covered under mandate, the nurse must be certified as a clinical nurse specialist and participate in expert clinical practice in the specialty of psychiatric-mental health nursing.
Audiologist	Nondiscrimination mandate
Autism Service Providers	For purposes of the behavioral health treatment mandate, a "qualified autism service provider" means either of the following: • A person, entity or group that is certified by a national entity (such as the Behavior Analyst Certification Board), that is accredited by the National Commission for Certifying Agencies, and that designs, supervises or provides treatment for pervasive developmental disorder or autism; or • A person licensed as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist who designs, supervises or provides treatment for pervasive developmental disorder or autism.
Chiropractor	Nondiscrimination mandate
Clinical Social Worker	Nondiscrimination mandate
Dentist	Nondiscrimination mandate
Marriage and Family Therapists	Nondiscrimination mandate. "Marriage and family therapist" means a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis and counseling, and psychotherapeutic treatment of premarital, marriage, family and child relationship dysfunctions.
Optometrist	Nondiscrimination mandate
Physician/Surgeon	Nondiscrimination mandate
Podiatrist	Nondiscrimination mandate
Professional Clinical Counselor	Nondiscrimination mandate. A "professional clinical counselor" means a licensed professional clinical counselor who has received specific instruction in assessment, diagnosis, prognosis, counseling and psychotherapeutic treatment of mental and emotional disorders.
Psychologist	Nondiscrimination mandate
Registered Dispensing Optician	Nondiscrimination mandate
Registered Nurse	Nondiscrimination mandate. To be covered under mandate, a nurse must possess a master's degree in psychiatric-mental health nursing and be listed as a psychiatric-mental health nurse by the Board of Registered Nursing.

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Respiratory Care Practitioner	Nondiscrimination mandate
Therapists – Occupational, Physical and Speech-Language	Nondiscrimination mandate

PERSON MANDATE	DESCRIPTION
Continuation Coverage (Cal-COBRA)	Insurers that provide coverage under a group plan to a small employer (employers with **fewer than 20 employees**) must offer continuation coverage to a qualified beneficiary when a qualifying event occurs. The maximum coverage period is **36 months**. The coverage must generally be provided under the same terms and conditions that apply to similarly situated individuals under the group plan. A "qualified beneficiary" means any individual who, on the day before the qualifying event, is covered under the group plan and has a qualifying event. "Qualifying event" means any of the following events that, but for the election of continuation coverage, would result in a loss of coverage: • The covered employee's death; • The covered employee's termination of employment or reduction in hours (except for terminations due to gross misconduct); • The covered employee's divorce or legal separation from his or her spouse; • A dependent's loss of dependent status; and • With respect to a covered dependent only, the covered employee's entitlement to benefits under Medicare. In addition, an insurer must offer a coverage extension to an insured or enrollee who has exhausted his or her 18 months (or longer in special circumstances) of federal COBRA coverage. The extension may be for up to 36 months from the date the individual's continuation coverage began.
Dependent Child – Limiting Age	For health insurance policies and health care service plans that provide dependent coverage, the limiting age for dependent children cannot be less than **age 26**. However, for plan years beginning before Jan. 1, 2014, a health insurance policy or health care service plan with grandfathered status under the federal health care reform law may exclude from coverage an adult child who has not attained 26 years of age if the adult child is eligible to enroll in an eligible employer-sponsored health plan, other than a group health plan of a parent.
Dependent Child – Not Residing with Employee	Health insurance policies and health care service plans cannot exclude a dependent child from eligibility or benefits solely because the dependent child does not reside with the employee.
Dependent Child – Students	If a health insurance policy or health care service plan provides coverage for a dependent child who is over 26 years of age and enrolled as a full-

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	time student at a secondary or postsecondary educational institution, the following conditions must apply to the coverage: • Any break in the school calendar cannot disqualify the dependent child from coverage; • If the dependent child takes a medical leave of absence and the child's condition renders him or her incapable of self-sustaining employment, the child's coverage must continue if he or she is chiefly dependent on the policyholder or subscriber for support and maintenance; • If the dependent child takes a medical leave of absence from school (but the dependent child's condition does not fall under the paragraph above) the child's coverage cannot terminate for a period of 12 months or until the date coverage is scheduled to terminate pursuant to the policy's or plan's terms, whichever comes first.
Disabled Child	If a plan or policy has a limiting age for dependent coverage, coverage must continue past the limiting age for a child who is (and continues to be) both incapable of self-sustaining employment by reason of an intellectual disability or physical handicap and chiefly dependent upon the insured for support and maintenance.
Domestic Partner Coverage	Health insurance policies and health care service plans must provide equal coverage to the registered domestic partner of an employee, insured, policyholder or subscriber to the same extent, and subject to the same terms and conditions, as provided to a spouse. In addition, policies and plans cannot discriminate in coverage between spouses or domestic partners of a different sex and spouses or domestic partners of the same sex.
Newborns and Adopted Minors	Health insurance policies and health care service plans that provide dependent coverage must provide coverage for newborn infants from and after the moment of birth and for any minor child placed for adoption from and after the moment the child is placed for adoption.
Persons with Dementia	Except for a preexisting condition, health insurance policies and health care service plans that provide coverage for long-term care facility services or home-based care cannot excluded covered persons from this coverage if they are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function (such as Alzheimer's disease and other progressive, degenerative and dementing illnesses).

**While many of the mandates described in the above chart are applicable to managed care plans, such as health maintenance organizations (HMOs) and certain preferred provider organizations (PPOs), managed care plans may be subject to additional requirements under California 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.*

Additional Resources:

California statutes: www.legislature.ca.gov

California Department of Insurance: www.insurance.ca.gov

California Department of Managed Care: www.dmhc.ca.gov