List of Mandated Health Insurance and HMO Benefits

The term "mandatory health insurance benefits" is subject to different interpretations. Broadly interpreted to include any coverage requirement, mandatory benefits include: (1) required policy benefits; (2) required offer of benefits; (3) required payment to a class of providers; and (4) required coverage of insureds and other underwriting restrictions. Florida has currently mandated health benefits for each of these categories be as follows:

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
1.	Acupuncturists	If a policy provides coverage for acupuncture, the policy must cover the services of an acupuncturist certified pursuant to chapter 457 under the same conditions that apply to services of a licensed physician.	627.6403	627.6618 Small group: 627.6699(12)(b)7	Not required	Not Required	Not Required
2.	Ambulatory Surgical Centers	A policy must provide coverage for any service performed in an ambulatory surgical center, as defined in s. 395.002, if such service would have been covered as an eligible inpatient service.	627.6056	627.6616 Small group: 627.6699(12)(b)7	Not required	Not Required	627.6616
3.	Birthing Centers and Nurse Midwives	A policy or HMO contract that provides coverage for maternity care must cover the services of certified nurse midwives and midwives licensed under chapter 467, and birth centers licensed under ss. 383.30-383.335.	627.6406	627.6574 Small group: 627.6699(12)(b)7	641.31(18)	627.6515(2)(c)	627.6699(12)(b)7
4.	Bone Marrow Transplants	The policy may not exclude coverage for bone marrow transplant procedures recommended by referring and treating physicians under a policy exclusion for experimental or investigative procedures if the particular use of the procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to rules adopted by the Agency for Health Care Administration, based on the recommendations of an advisory panel. Procedures must include costs associated with the donor-patient.	627.4236	627.4236	627.4236	Not required	627.4236 (But limited coverage provided in Standard)
5.	Cancer Drugs	If a policy covers the treatment of cancer, an insurer may not exclude coverage for any prescribed drug on the ground that the drug is not approved by the U.S. Food and Drug Administration, if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medial literature, unless the FDA has determined that the use of the drug is contra-indicated or has not otherwise approved the drug for any indication.	627.4239	627.4239	Not required	Not required	Not required
6.	Child Health Supervision Services	Policy benefits for children must include coverage for child health supervision services from birth to age 16 and be exempt from any deductible. Services include a physical examination, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.	627.6416	627.6579	641.31(30)	627.6515	627.6699(12)(b)4

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7.	Children: Adopted and Foster Children	Benefits applicable to children apply to an adopted child and foster child from the moment of placement in the residence. Coverage begins at the moment of birth if a prior written agreement to adopt the child has been executed. The policy may not exclude coverage for any preexisting condition except in the case of a foster child. For HMOs and small group policies, only the benefits applicable to adopted children apply.	627.6415	627.6578 Small group: 627.6699(12)(b)4 (adopted only)	641.31(17) (adopted only)	Not required	627.6578(12)(e)
8.	Children: Handicapped	Policies covering children must continue to provide coverage beyond the age limit for dependent children as long as the child continues to be incapable of self-sustaining employment due to mental retardation or physical handicap; and is chiefly dependent on the policyholder or subscriber for support.	627.6615	627.6578 & 627.6615 Small group: 627.6699(12)(b)4	641.31(29)	Not required	627.6699(12)(b)4
9.	Children: Newborn Coverage	Policies covering a family member of the insured must provide coverage for a newborn child from the moment of birth. The policy must also cover the newborn child of a covered family member (son or daughter), which coverage terminates 18 months after birth.	627.641	627.6575 Small group: 627.6699(12)(b)4	641.31(9)	627.6515(2)(c)	627.6699(12)(b)4
10.	Children:Dependent Coverage to Age 25	Group health insurance policies that insure dependent children must continue coverage at least until the end of the calendar year in which the child reaches age 25 if the child is dependent upon the policyholder or certificateholder for support and the child is either living in the household of the certificateholder or is a full-time or part-time student.	Not required	627.6562	Not required	Not required	Not required (But included in the policy)
11.	Chiropractors	A health insurance policy must be construed to include payment to a chiropractic physician who provides covered benefits or procedures within the scope of his or her license. (Not applicable to HMOs.)	627.419(4)	627.419(4) Small group: 627.6699(12)(b)7	Not required	627.419(4)	627.6699(12)(b)7
12.	Cleft Lip/Palate for Children	Policy benefits for a child under age 18 must include treatment of cleft lip and cleft palate, including medical, dental, speech therapy, audiology, and nutrition services if prescribed by the treating physician or surgeon and certified as medically necessary.	627.64193	627.66911 Small group: 627.6699(12)(b)7	641.31(35)	627.6515(2)(c)	627.6699(12)(b)7
13.	Continuation of Group Coverage	Group policies covering fewer than 20 employees must allow an employee to continue coverage for 18 months (or 29 months for handicapped individuals; 36 months for divorced and widowed spouses) after their group coverage would otherwise terminate, subject to payment of up to 115% of the group premium. (Comparable to the federal COBRA law for employers with 20 or more employees.)	Not required	Small group: 627.6692	Small group: 627.6692	Not required	Small group: 627.6692

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14.	Continued Coverage with Terminated Provider	If a contract between an HMO and a provider is terminated for any reason other than for cause, each party shall allow HMO subscribers for whom treatment was active, to continue coverage through completion of medically necessary treatment, until the subscriber picks another provider, or during the next open enrollment period offered by the HMO, not to exceed 6 months or through postpartum care if pregnant.	Not required	Not required	641.51(8)	Not Required	Not Required
15.	Conversion to Individual Coverage	After group coverage (large or small) terminates (after any COBRA extension), the insurer or HMO must offer an individual conversion policy.	Not required	627.6675	641.3921 & 641.3922	627.6515(2)(c)	Not required (But included in the policy)
16.	Denial of Coverage due to Breast Cancer	An insurer or HMO may not exclude or deny coverage solely because the insured has been diagnosed as having a fibrocystic condition or a nonmalignant lesion that demonstrates a predisposition to, or solely due to a family history of, breast cancer, unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer. Coverage also may not be denied nor canceled solely due to breast cancer if the insured has been free from breast cancer for more than 2 years before request for coverage.	627.6419	627.6419	627.6419	Not required	Not required
17.	Dental Care (Employer Offer of Open-Panel Plan)	Any employer, group, or organization that pays or contributes to the premiums of a group health plan or dental service plan which provides dental coverage only through an exclusive list of dentists must provide an alternative to enable the insured to have a free choice of dentist. (Note: This requirement applies to employers, not insurers.)	Not required	627.6577	Not required	Not Required	Not Required
18.	Dental Procedures for Children: General	If the policy provides coverage for general anesthesia and hospitalization services, such services must be provided for dental care to a person under age 8, if the dental condition is likely to result in a medical condition if left untreated and if the child's dentist and physician determine dental treatment in a hospital or ambulatory surgical center is necessary due to the complex nature of the procedure or due to a significant or undue medial risk.	627.4295	627.65755	641.31(34)	Not Required	Not Required
19.	Dentists	The word "physician" when used in a health insurance policy providing for the payment of surgical procedures performed in an accredited hospital in consultation with a licensed physician must be construed to include payment to a dentist who provides benefits or procedures within the scope of his or her license.	627.419(2)	627.419(2) Small group: 627.6699 (12)(b)7	Not required	627.419(2)	627.419(2)

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20.	Dermatologists (Direct Access)	HMO contracts and insurer EPO contracts must provide direct access (without referral or authorization) for up to five office visits annually, including minor procedures and testing, to a dermatologist who is under contract with the insurer or HMO.	627.6472(16)	627.6472(16) & 627.662	641.31(33)	Not Required	Not Required
21.	Diabetes Treatment	Policy must cover all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary.	627.6408	627.65745	641.31(26)	Not Required	627.65745
22.a.	Emergency Care (EPO)	Insurers issuing exclusive-provider organization (EPO) contracts must cover non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.	627.6472	627.6472	Not Required	Not Required	Not Required
22.b.	Emergency Care (HMO)	HMOs must provide coverage, without prior authorization, for emergency care (screening and stabilization) based on determination by hospital physician or appropriate licensed professional hospital personnel under supervision of physician, provided by either a participating or nonparticipating provider.	Not required	Not required	641.513(3) & 641.31(12)	Not Required	641.513(3) & 641.31(12)
23.	Enteral Feeding Formulas/ Treatment of PKU	The policy must make available to the policyholder (e.g., to an employer under a group policy) as part of the application, for an appropriate additional premium, coverage for prescription and non-prescription enteral formulas (nutrient and food supplements) for home use which are prescribed by a physician as medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism or for malabsorption originating from congenital defects or acquired during the neonatal period. The coverage may not exceed $2,500 per year for an insured through age 24.	627.42395	627.42395	Not required	Not Required	Not Required
24.	Extension of Benefits	Group policy must provide for a 12-month extension of major medical benefits for a person who is totally disabled at the date of discontinuance of the policy, regardless of whether replacement coverage is obtained. Specific requirements apply to extension of benefits for maternity expense and dental procedures. (The requirements for dental procedures do not apply to HMOs.)	Not required	627.667	641.3111	627.6515(2)(c)	Not Required (But included in the policy)

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25.	Guaranteed Availability of Individual Coverage (HIPAA-Eligible)	Persons who lose coverage after being covered for at least 18 months, the most recent of which is group coverage, are entitled to individual coverage. If the prior coverage is under an insured group plan, the group insurer must offer an individual conversion policy. If the prior coverage is with a self-insured plan, coverage may be obtained on a guaranteed-issue from any insurer or HMO issuing individual coverage. Persons who lose eligibility for individual coverage issued in Florida due to the insurer becoming insolvent, the insurer discontinuing all coverage in the state, or the individual moving out of the service area of the insurer or HMO, are entitled to guaranteed-issuance of coverage from any individual carrier.	627.6487	627.6487	627.6487	627.6487	627.6487
26.	Guaranteed Renewability	All individual and group policies and group HMO contracts must be guaranteed renewable, subject to certain exceptions.	627.6487	627.6571 Small group: 627.6699(7)	641.31074	627.6571 (Small group and bona fide associations)	627.6699(7)
27.	HIV Coverage	A policy may not exclude coverage for HIV-infection or acquired immune deficiency syndrome, except as provided in a preexisting condition exclusion.	627.411; 627.429	627.411; 627.429 Small group: 627.6699(6)(d)	641.3007	627.429	627.429 & 641.3007
28.	Home Health Care Services	A group policy must provide coverage of a least $1,000 per year for home health care by a licensed home health care agency, as prescribed by a licensed physician.	Not required	627.6617	Not required	Not Required	Not Required (But required in the policy)
29.	Mammograms	Policy must include coverage for a baseline mammogram for a woman age 35-39, a mammogram every two years for a woman age 40-49, every year for a woman age 50 or older, and one or more a year based on a physician's recommendation for a woman who is at risk for breast cancer based on specified criteria.	627.6418	627.6613 Small group: 627.6699(12)(b)4	641.31095	627.6515(2)(c)	627.6418 & 641.31095
30.	Massage Therapists	If a policy or HMO contract provides coverage for a massage, it must cover the services of a person licensed to practice massage under chapter 480, if the massage is prescribed as medically necessary by a physician licensed under chapters 458, 459, 460, or 461, and the prescription specifies the number of treatments.	627.6407	627.6619	641.31(37)	Not Required	Not Required
31.	Mastectomy: Length of stay and out-patient coverage	A policy that provides coverage for breast cancer may not limit in-patient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient. Must also provide coverage for outpatient post-surgical follow-up care in keeping with prevailing medical standards by a licensed health care professional qualified to provide such care.	627.64171	627.66121 Small group: 627.6699(12)(b)7	641.31(31)	627.6515(2)(c)	627.6699(12)(b)7

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32.	Mastectomy: Surgical Procedures and Devices	If the policy provides coverage for a mastectomy, coverage must include prosthetic devices and breast reconstructive surgery incident to a mastectomy.	627.6417	627.6612 Small group: 627.6699(12)(b)7	641.31(32)	627.6515(2)(c)	627.6699(12)(b)7
33.	Maternity Care: Length of Stay and Post-Delivery Care	A policy that provides coverage for maternity benefits or newborn coverage may not limit coverage for length of stay in a hospital or for follow-up care outside of a hospital to any time period less than that determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider, in accordance with prevailing medical standards. The policy must provide coverage for post-delivery care for the mother and infant, including medically necessary clinical tests and immunizations.	627.6406	627.6574 Small group: 627.6699(12)(b)7	641.31(18)	627.6515(2)(c)	627.6699(12)(b)7
34.	Mental and Nervous Disorders	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, for an appropriate additional premium, coverage for mental and nervous disorders. If mental health benefits are elected, coverage must include at least 30 days of in-patient coverage and at least $1,000 per year for outpatient benefits for consultations with a licensed physician, psychologist, mental health counselor, marriage and family therapist, and clinical social worker.	Not required	627.668 Small group: 627.6699(12)(b)7	627.668	Not Required	627.668 (But with different limits)
35.	Newborn Hearing Screening	Policies covering a family member of the insured must provide coverage for the initial hearing screening and any medically necessary follow-up reevaluations leading to diagnosis shall be a covered benefit. Medicaid recipients' services (including those in Medicaid HMOs or PSNs) will be reimbursed as fee-for-service (Medicaid rate) and other insurers will be reimbursed at the contracted rate.	627.6416	627.6579	641.31(30)	627.6515(2)(c)	627.6699(12)(b)4d
36.	Nurse Anesthetist	HMO contracts that provide anesthesia coverage or services shall offer to the subscriber if requested and available, the services of a licensed certified registered nurse anesthetist.	Not required	Not required	641.31(21)	Not Required	Not Required
37.	OB/GYN Annual Visit	Insurers issuing EPO contracts and HMOs must allow, without prior authorization, a female subscriber to visit a contracted OB/GYN for one annual visit and for medically necessary follow-up care detected at that visit.	627.6472(18)	627.6472(18) & 627.662	641.51(11)	Not Required	Not Required
38.	OB/GYNs	HMO must allow each female subscriber to select as her primary physician an obstetrician/gynecologist. (Also see Table 1, OB/GYN Annual Visit)	Not required	Not required	641.19(13)(e)	Not Required	HMO only: 641.19(13)(e)
39.	Ophthalmologist	Insurance policy and HMO contracts which provide coverage or services that are performed by physicians who are ophthalmologists, licensed under chapter 458 or 459, must offer the subscriber the services of an ophthalmologist.	627.419(2)	627.419(2)	641.31(20)	627.419(2)	627.6699(12)(b)7

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40.a.	Optometrists	A health insurance policy that provides coverage for services within the scope of an optometrist's licenses shall be construed to include payment to an optometrist who performs such procedures.	627.419(3)	627.419(3) Small group: 627.6699(12)(b)7	Not required	627.419(3)	627.6699(12)(b)7
40.b.	Optometrists (HMO)	HMO contracts that provide coverage or services as described in s. 463.002(5), must offer to the subscriber the services of an optometrist licensed under chapter 463.	Not required	Not required	641.31(19)	Not Required	627.6699(12)(b)7
41.	Osteopathic Hospitals	Small employer policies and HMO contracts that provide for inpatient and outpatient services by allopathic hospitals must provide as an option for the patient or subscriber similar inpatient and outpatient services by an osteopathic hospital when the services are available in the HMO service area.	Not required	Small group only: 627.6699(12)(b)8	641.31(24)	Not required	Not required (But included in the policy)
42.a.	Osteopaths	For insurance policies a physician licensed under chapter 459 (osteopaths).	627.419(2)	627.419(2)	641.19(13)(d)	627.419(2)	Not required (But included in the policy)
42.b.	Osteopaths (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not required	Not required
43.	Osteoporosis Diagnosis and Treatment	Policy must provide coverage for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including individuals with a family history of osteoporosis and other specified high-risk criteria.	627.6409	627.6691	641.31(27)	Not Required	Not Required
44.	Out-of-Hospital Services	Policy must provide coverage for treatment provided outside a hospital if such treatment would be covered on an in-patient basis and is provided by a health care provider whose services would be covered under the policy if performed in a hospital.	627.4232	627.4232	Not required	Not Required	Not Required
45.a.	Podiatrists	A health insurance policy that provides coverage for services within the scope of a podiatrist's license shall be construed to include payment to a podiatrist who performs such procedures.	627.419(3)	627.419(3) Small group: 627.6699(12)(b)7	Not required	627.419(3)	627.6699(12)(b)7
45.b.	Podiatrists (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not required	627.6699(12)(b)7
46.a.	Preexisting Conditions	Individual health insurance policies and individual HMO contracts may not exclude preexisting conditions for more than 24 months and may relate only to conditions that manifested themselves during the 24-month period before coverage. However, the policy may exclude coverage for named or specific conditions without any time limit.	627.6045 & 627.607	Not required	4-191.024(17) (Individual only)	Not required	Not required

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46.b.	Preexisting Conditions	Group policies and group HMO contracts may not exclude preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee, and may relate only to conditions that manifested themselves during the 6-month period prior to coverage. The period of the exclusion is reduced by the time the insured was covered under prior creditable coverage.	Not required	627.6561	641.31071	Not required	627.6699(5)(f)
47.	Primary Care Physicians	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not Required	Not Required
48.	Psycho-therapeutic Providers	An insurer issuing coverage through preferred providers (PPO policies) or through exclusive providers (EPO policies) that cover psychotherapeutic services, must provide eligibility requirements for all groups of health care providers licensed under chapter 458, 4359, 490 or 491, which include psychotherapy in their scope of practice, and certified advanced registered nurse practitioners in psychiatric mental health under s. 464.012.	627.6471 & 627.6472	627.6471, 627.6472 & 627.668	Not required	Not required	Not required
49.	Special Enrollment Periods	Insurers and HMOs issuing group health policies and contracts must: 1) allow an employee to enroll who previously did not enroll due to having other coverage, and the other coverage terminates due to certain conditions; 2) allow a person to enroll who becomes a dependent of a covered person by reason of marriage, birth, or adoption.	Not required	627.65615	641.31072	Not required	627.6699(5)(h)7
50.	Substance Abuse	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, specified benefits for substance abuse, subject to the right of the applicant to select any alternative benefits as may be offered. The specified level of benefits that must be offered must have a minimum lifetime benefit of $2,000, a maximum of 44 out-patient visits, and a maximum benefit of $35 per outpatient visit. Treatment must be provided by, or under the supervision of, or prescribed by, a licensed physician or psychologist.	Not required	627.669	627.669	Not Required	Not Required
51.	TMJ	A policy that provides coverage for any diagnostic or surgical procedure involving bones or joints of the skeleton may not discriminate against coverage for such procedures involving bones or joints of the jaw and facial region if such procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.	627.419(7)	627.65735	641.31094	627.6515(7)	Not Required (But inculded in the policy)