

Texas Mandated Health Benefits

While every effort is made to ensure the accuracy of the information in this chart, please consult the Texas Insurance Code (TIC), the Texas Administrative Code (TAC), and other applicable state and federal laws about the extent and nature of applicable requirements. Applicable statutes and regulations govern; this chart should not be considered to provide legal guidance and is intended only as an educational resource.

Applicability:

The chart below shows the benefits that must be included in fully insured major medical plans in Texas. The state laws addressed in this chart do not apply to self-funded health plans commonly offered by large employers and exempted from state law by ERISA. Unless otherwise noted, these requirements apply both to plans offered by health maintenance organizations (HMOs) and carriers writing preferred provider benefit plans or exclusive provider benefit plans. More information regarding the required benefits is available via links to the applicable Texas statutes and rules. If you are concerned about the way your plan is providing a mandated benefit, you may [file a complaint](#) with the Texas Department of Insurance.

Interaction between state and federal law:

The chart reflects Texas requirements and is not designed to contain all federal requirements. The columns addressing state law for individual, small group, and large group plans describe the applicability of the Texas statutes as they were drafted. Since 2014, the federal Affordable Care Act (ACA) requires any health plan sold in the individual and small group market to include ten categories of Essential Health Benefits (EHBs), in addition to complying with state laws. The federal law (EHB) column reflects that most state mandates are considered EHBs, and in some cases, the federal EHB requirement effectively expands the applicability of the mandate to plans beyond those originally included in the state law. Certain mandated offers and laws specific to HMOs are not considered EHBs. These state laws continue to apply as described by the chart. [Read more about federal EHB requirements.](#)

Grandfathered and transitional plans:

If your health plan has been the same since before March 23, 2010 (when Congress passed the ACA), your plan might be “grandfathered” and exempt from some federal mandates. Additionally, some plans issued prior to 2014 are exempt from EHB requirements under a [transitional policy](#).

Consumer Choice Plans:

Texas law ([TIC Ch. 1507](#) and [28 TAC Ch. 21, Sub Ch. AA](#)) allows “[Consumer Choice Plans](#)” (CCPs), to exclude coverage for certain state mandates. But a CCP cannot exclude a benefit required by federal law. Applicable federal laws include:

- Affordable Care Act (ACA) of 2010 – includes essential health benefits (EHB) at [42 USC §18022](#) and [45 CFR Part 156, Subpart B](#), and coverage for [certain preventive services](#) without cost sharing at [42 USC §300gg-13](#)
- Newborns’ and Mothers’ Health Protection Act of 1996 – maternity minimum stay under [29 USC §1185](#) and [42 USC §300gg-51](#)
- Women’s Health and Cancer Rights Act of 1998 – breast reconstruction following mastectomy under [29 USC §1185b](#) and [42 USC §300gg-52](#)
- Pregnancy Discrimination Act of 1978 – via amendment to title VII of the Civil Rights Act of 1964 at [42 USC §2000e\(k\)](#)

The chart indicates whether a CCP plan must include coverage for each mandate and, where applicable, cites the reason the mandate applies.

Categories of Mandated Benefits	Federal Law (EHB): Individual & Small Group	State Law Sources	State Law: Individual	State Law: Small Group	State Law: Large Employer, Association Plans	State Law: Consumer Choice Plans (CCP)
HMO-specific mandates						
Basic health care services - without limit on time or cost	Yes; services are EHB but visit limits may apply	TIC Ch. 1271 Subch. D 28 TAC §11.508(d)	HMO only	HMO only - as applicable	HMO only	CCPs must cover but may impose time and cost limits
Rehabilitation therapies – constraints on coverage limits - without limit if meets treatment goals	Yes; services are EHB but visit limits may apply	TIC §1271.156	HMO only	HMO only	HMO only	CCPs must cover but may impose time and cost limits
HMO cost sharing restrictions: - copays may not exceed 50% of cost of service - copays may not exceed 200% of annual premium - no deductible may apply	No; federal actuarial value provisions and out-of-pocket maximums apply	28 TAC §11.506(b)(2)	HMO only	HMO only	HMO only	No; CCPs may impose deductibles and higher copayment amounts

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All other mandates						
Home health	Yes	TIC Ch. 1351 for insurance 28 TAC §11.508(a)(1)(G) for HMO	No (Required for HMO)	Offer (Required for HMO)	Offer (Required for HMO)	Yes – individual and small group (federal law); No – large group; (HMO must cover, but may apply limits)
Acquired brain injury	Yes	TIC Ch. 1352 28 TAC Ch. 21, Subch. W	Yes	Yes	Yes	Yes – individual and small group (federal law); No – large group
Autism spectrum disorder	Yes	TIC §1355.015 28 TAC Ch. 21, Subch. P, Div. 4	No	Yes	Yes	Yes – small group (federal law); No – large group
Parity for mental health and substance use disorders	Yes See also 42 USC §300gg-26 and 45 CFR §146.136	TIC §1355.254 28 TAC Ch. 21, Subch. P	Yes	Yes	Yes	Yes
Chemical dependency	Yes	TIC Ch. 1368 28 TAC Ch. 3, Subch. HH	No	Yes	Yes	<u>Chem. Dep.:</u> Yes – small group (federal law); No – large group

Categories of Mandated Benefits	Federal Law (EHB): Individual & Small Group	State Law Sources	State Law: Individual	State Law: Small Group	State Law: Large Employer, Association Plans	State Law: Consumer Choice Plans (CCP)
Serious mental illness , crisis stabilization unit, residential treatment center for children and adolescents, and psychiatric day treatment facilities;	Yes See also 42 USC §300gg-26 and 45 CFR §146.136	TIC Ch. 1355 - §1355.004 - §1355.053 - §1355.104	<u>SMI:</u> No	<u>SMI:</u> Offer	<u>SMI:</u> Yes	<u>SMI:</u> Yes TIC §1507.003(b)(7) and §1507.053(b)(6)
Offer – Inpatient treatment of mental or emotional illness or disorder;		TIC §1355.106	<u>Offer:</u> No	<u>Offer:</u> Yes	<u>Offer:</u> Yes	<u>Offer:</u> No
Limits on step therapy		TIC §1369.0547	Yes	Yes	Yes	<u>Limits on step therapy:</u> Yes Does not qualify as a “state mandated health benefit” under TIC §1507.003(a) and TIC §1507.053(a) that is eligible to be waived

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Reconstructive surgery following mastectomy; and Minimum stay for mastectomy or lymph node dissection	<u>Surgery:</u> Yes 42 USC §300gg-52	TIC Ch. 1357 28 TAC §11.508(b)(1)	<u>Surgery:</u> Yes	<u>Surgery:</u> Yes	<u>Surgery:</u> Yes	<u>Surgery:</u> Yes – federal law, Women’s Health and Cancer Rights Act of 1998; <u>Minimum stay:</u> Yes – individual (federal law); No – large group
Diabetes – Minimum coverage; services, supplies, self-management training, and emergency refills	Yes	TIC Ch. 1358 Subchapters A and B 28 TAC Ch. 21, Subch. R 28 TAC §11.508(b)(3)	Yes	No	Yes	<u>Subchapter A:</u> No <u>Subchapter B and rules:</u> Yes TIC §1507.003(b)(6) 28 TAC §11.508(b)(3)
Limits on cost-sharing		TIC Ch. 1358, Subch. C	Yes	Yes	Yes	<u>Subchapter C:</u> No
Formulas for phenylketonuria (PKU) or other Heritable Diseases	Yes	TIC Ch. 1359 28 TAC §11.509(6)	No	Yes	Yes	Yes TIC §1507.003(b)(10) 28 TAC §11.509(6)
Temporomandibular joint (TMJ)	Yes	TIC Ch. 1360	No	No	Yes	No

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In vitro fertilization	No	TIC Ch. 1366, Subch. A	No	Offer	Offer	No
Maternity minimum stay – if maternity is covered; Complications of pregnancy covered as any other illness	Yes	TIC Ch. 1366, Subch. B 28 TAC §11.508(b)(2) 42 USC §300gg-51 28 TAC §21.405 42 USC §2000e(k)	Yes	Yes	Yes	Yes federal law: Newborns’ and Mothers’ Health Protection Act of 1996; and Pregnancy Discrimination Act of 1978
Fertility preservation services related to cancer treatment	No	TIC Ch. 1366, Subch. C	Yes	Yes	Yes	Yes TIC §1366.102(b)(2)
Reconstructive Surgery for craniofacial abnormalities	Yes	TIC Ch. 1367, Subch. D	Yes	No	Yes	Yes TIC §1507.003(b)(9) 28 TAC §11.509(5)
Hearing aids and cochlear implants for children; Offer of speech and hearing; and choice of hearing aid	Yes	TIC Ch. 1367, Subch. F TIC Ch. 1365	<u>Children:</u> Yes <u>Offer:</u> No	<u>Children:</u> Yes <u>Offer:</u> Yes	<u>Children:</u> Yes <u>Offer:</u> Yes	<u>Children:</u> Yes <u>Offer:</u> Yes – small group (federal law); No – large group

Categories of Mandated Benefits	Federal Law (EHB): Individual & Small Group	State Law Sources	State Law: Individual	State Law: Small Group	State Law: Large Employer, Association Plans	State Law: Consumer Choice Plans (CCP)
Developmental delays	Rehabilitative and habilitative therapies are covered, but visit limits may apply	TIC Ch. 1367, Subch. E	Offer	No	Offer	No
Off-label drugs for chronic, disabling, or life-threatening illness	Yes	TIC Ch. 1369 Subch. A 28 TAC Ch. 21, Subch. V, Division 3	Yes	No	Yes	No
Oral anticancer medications	Yes	TIC Ch. 1369, Subch. E	Yes	Yes	Yes	Yes – individual and small group (federal law); No – large group
Ovarian cancer, diagnostic examination (including CA-125 or any other FDA-approved test for ovarian cancer.)	Yes (diagnostic, laboratory services)	TIC Ch. 1370	Yes	Yes	Yes	Yes TIC §1507.003(b)(12)(D) and §1507.053(b)(7)(D)
Prosthetic and orthotic devices and related services	Yes	TIC Ch. 1371	Yes	Yes	Yes	Yes – individual and small group (federal law); No – large group

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Biomarker testing	Yes (diagnostic, laboratory services)	TIC Ch. 1372	Yes	Yes	Yes	Yes TIC §1372.002(b)(2)
Gender transition - reversal or treatment of adverse effects (Required only for a plan that has provided coverage for gender transition)	No Some screenings and treatment included if medically necessary	TIC Ch. 1373	Yes	Yes	Yes	Yes TIC §1373.002(b)(2)
Amino acid-based formulas	Yes	TIC Ch. 1377	Yes	Yes	Yes	Yes – individual and small group (federal law); No – large group
Transplant donor coverage	Yes	28 TAC §3.3040(h)	Yes	No	No	Yes – individual (federal law); No – large group

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Preventive Services						
Breast cancer screening and diagnostic imaging (Starting at age 35, includes ultrasound, MRI, and 2D or 3D mammography.)	Yes also federal preventive services include mammography starting at age 40	TIC Ch. 1356 <i>See also TIC Ch. 1653, which allows an HSA-qualified plan to apply cost-sharing beyond what would otherwise be permitted under 1356.005(a-1)</i> 28 TAC §11.508(a)(1)(H)(iv)	Yes	Yes	Yes	Yes TIC §1356.002(h) §1507.003(b)(12)(A) §1507.053(b)(7)(A) and federal law
Osteoporosis screening	Yes also federal preventive service	TIC Ch. 1361	No	Yes	Yes	Yes federal law, ACA preventive services
Prostate cancer screening	Yes	TIC Ch. 1362 TIC §1575.159 28 TAC §11.508(a)(1)(H)(iv)	Yes	No	Yes	Yes TIC §1507.003(b)(12)(B) §1507.053(b)(7)(B)
Colorectal cancer screening (Specified services starting at age 45. Cost-sharing limits apply.)	Yes also federal preventive service	TIC Ch. 1363 28 TAC §11.508(a)(1)(H)(iv)	Yes	No	Yes	Yes TIC §1507.003(b)(12)(C) §1507.053(b)(7)(C)

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Immunizations through age 6 without cost-sharing	Yes also federal preventive service	TIC Ch. 1367 Subch. B 28 TAC §11.508(a)(1)(H)(ii)	Yes	No	Yes	Yes TIC §1507.003(b)(8) 28 TAC §11.508(a)(1)(H)(ii) and federal law
Newborn hearing screening	Yes also federal preventive service	TIC Ch. 1367, Subch. C 28 TAC §11.508(a)(1)(H)(v)	Yes	No	Yes	Yes TIC §1507.003(b)(8) 28 TAC §11.508(a)(1)(H)(v) and federal law
Newborn screening	Yes also federal preventive service	TIC §1271.154 TIC §1367.003 28 TAC §11.508(a)(1)(H)(iii)	Yes	Yes	Yes	Yes TIC §1507.003(b)(4)(B) and federal law, ACA preventive services
Prescription contraceptive drugs and devices and related services; 12-month supply	Yes subject to religious exemption also federal preventive service	TIC Ch. 1369 Subch. C 28 TAC §21.404	Yes subject to religious exemption	Yes subject to religious exemption	Yes subject to religious exemption	Yes federal law, ACA preventive services, subject to religious exemption

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Human papillomavirus and cervical cancer screening (including a pap smear or FDA-approved HPV test)	Yes also federal preventive service	TIC Ch. 1370	Yes	Yes	Yes	Yes TIC §1507.003(b)(12)(D) and §1507.053(b)(7)(D) and federal law
Cardiovascular disease screening	Yes	TIC Ch. 1376	Yes	Yes	Yes	Yes – individual and small group (federal law); No – large group

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Prohibited Exclusions and Other Coverage Standards						
Alzheimer's disease – a clinical diagnosis satisfies any requirement for proof of organic disease	Yes	TIC Ch. 1354	Yes	Yes	Yes	Yes Does not qualify as a "state mandated health benefit" under TIC §1507.003(a) and TIC §1507.053(a) that is eligible to be waived
Dental anesthesia in certain individuals – may not exclude coverage for those unable to undergo dental treatment in an office setting or under local anesthesia	No	TIC §1360.005 28 TAC §11.509(4)	<u>Certain individuals</u> No	<u>Certain individuals</u> No	<u>Certain individuals</u> Yes	<u>Certain individuals</u> Yes Does not qualify as a "state mandated health benefit" under TIC §1507.003(a) and TIC §1507.053(a) that is eligible to be waived
Children under 13		TIC §1367.302	<u>Children</u> Yes	<u>Children</u> Yes	<u>Children</u> Yes	<u>Children</u> No TIC §1367.301(b)(2)

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HIV, AIDS, OR HIV-Related Illnesses – a plan may not exclude, deny, or cancel coverage	Yes also federal preventive services include HIV prevention treatment	TIC Ch. 1202, Subch. B for individual plans TIC Ch. 1364 for group plans	Prohibition on cancellation	Yes	Yes	Yes Does not qualify as a “state mandated health benefit” under TIC §1507.003(a) and TIC §1507.053(a) that is eligible to be waived
Telemedicine, Teledentistry, and Telehealth – covered services may not be excluded solely because not provided in-person	No (but state law applies)	TIC Ch. 1455	Yes	No	Yes	Yes Does not qualify as a “state mandated health benefit” under TIC §1507.003(a) and TIC §1507.053(a) that is eligible to be waived
Emergency care – covered in- or out-of-network in an HMO, EPO, or PPO with protections from balance billing	Yes	TIC §1271.155 for HMO TIC §1301.155 for PPO and EPO TIC §1201.060 for non-network plans 28 TAC §11.508(a)(1)(J)	Yes	Yes	Yes	Yes Does not qualify as a “state mandated health benefit” under TIC §1507.003(a) and TIC §1507.053(a) that is eligible to be waived