Minnesota HMO Certificate of Coverage Reviewer Checklist—Required Medical Benefits

HMOs must cover all "medically necessary"[1] "comprehensive health maintenance services"[2] without limitations or exclusions, except as expressly authorized by statute and rules.[3] HMOs may use utilization management consistent with Minnesota law.[4]

HMOs must maintain a network to provide services that meet geographic requirements[5] and provide a sufficient number and types of providers to meet the projected needs of enrollees.[6]

No lifetime limits, annual limits on specific services, or visit limits are allowed,[7] except as described below.

Individual and small group products must cover essential health benefits[8] and all benefits included in state benchmark plan, but are allowed to limit or exclude acupuncture, bariatric surgery and adult eye examinations per federal regulations and benchmark plan. [9]

Large group plans are not required to cover essential health benefits, but must cover all HMO state mandated benefits required by Minnesota laws and rules, including acupuncture, bariatric surgery, adult eye examination and autism therapies.

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[1] Minn. Rule 4685.0100, subp. 9b.
[2] Minn. Rule 4685.0100, subp. 5; 4685.0700, subp. 2
[3] Minn. Rule 4685.0700, subp. 3 and 4.
[4] Minn. Stat. 62M
[5] Minn. Stat. 62D.124; Minn. Stat. 62K.10
[6] Minn. Rule 4685.1010
[7] Minn. Rule 4685.0700 states HMOs must provide all medically necessary services delineated except as specific limitations or exclusions are allowed in the rule; Minn. Stat. 62D.04, subd. 4 HMO "arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee."

[8] 42 U.S. Code § 18022; 45 CFR 147.150; 62Q.81
[9] https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb#Minnesota

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
Primary Care			
HMOs must cover primary care. HMO may use “gate-keeper” models requiring primary care providers to refer all specialty services, but most HMOs now offer options for “open access” or “Preferred Provider Organization/PPO” models allowing enrollees to directly access all specialists within a designated network without obtaining a referral from primary care clinic. HMOs may define what providers are considered “primary care” beyond primary care physicians. However, HMOs must allow open access to certain providers by law, including obstetrics and gynecology and pediatrics. If enrollees are required to designate primary care physicians, this must be clearly stated in coverage documents.	All: individual, small group and large group	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 applies to all HMO products: Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment. 4685.0100 Subp. 12a. Primary care physician. "Primary care physician" means a licensed physician, either employed by or under contract with the health maintenance organization, who is in general practice, or who has special education, training, or experience, or who is board-certified or board-eligible and working toward certification in a board approved by the American Board of Medical Specialists or the American Osteopathic Association in family practice, pediatrics, internal medicine, or obstetrics and gynecology.	Individual and small group plans must cover all “essential health benefits” (EHB) as defined by federal regulations. EHB includes primary care. Individual and small group plans must also cover all benefits included in the state benchmark plan. The state benchmark plan must cover all services defined as essential health benefits as required by 45 CFR 156.110. Essential health benefits is defined in 42 USC 18022 as follows: https://www.law.cornell.edu/uscode/text/42/18022 (**A) Ambulatory patient services.** (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. **(I) Preventive and wellness services and chronic disease management.** **(J) Pediatric services, including oral and vision care.** Essential health benefits defined in 45 CFR 156 as well. https://www.law.cornell.edu/cfr/text/45/156.110

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		Subp. 12b. Primary care provider. "Primary care provider" means a primary care physician as defined in subpart 12a or a licensed practitioner such as a licensed nurse, optometrist, or chiropractor who, within that practitioner's scope of practice as defined under the relevant state licensing law, provides primary care services. Minn. Stat. 62Q.81 applies to individual and small group plans and requires these plans to cover all essential health benefits designated by federal law. Subdivision 1. Essential health benefits package. (a) Health plan companies offering individual and small group health plans must include the essential health benefits package required under section 1302(a) of the Affordable Care Act and as described in this subdivision. (b) The essential health benefits package means coverage that: (1) provides essential health benefits as outlined in the Affordable Care Act;	For a group plan, an enrollee can designate a pediatrician as primary care provider for a child per 29 CFR § 2590.715-2719A. https://www.law.cornell.edu/cfr/text/29/2590.715-2719A A group plan must allow direct access to obstetric and gynecological care for women enrollees per 29 CFR § 2590.715-2719A. https://www.law.cornell.edu/cfr/text/29/2590.715-2719A A group plan must provide notice in the coverage documents as follows: Notice of right to designate a primary care provider - (i) In general. If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights - (A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant or beneficiary can be designated; (B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
			(C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. https://www.law.cornell.edu/cfr/text/29/2590.715-2719A
Preventive Care			
HMOs must cover all medically necessary preventive care. Per Minn. Stat. 62D.095, only US Preventive Service Task Force (USPSTF) A and B services are required to be covered without cost-sharing. If a preventive service is required by state law or rule, but is not an A or B services, it still must be covered, but an HMO can impose cost sharing. HMO must describe services with reasonable specificity in certificate of coverage and should list basic services. It is acceptable to link to current list of USPSTF A and B services in certificate of coverage	All	Minn. Rules 4685.0100, subp. 5E; 4685.0700, subp. 2: “Comprehensive Health Maintenance Services” includes: "Preventive health services," defined as health education, health supervision including evaluation and follow-up, immunization and early disease detection. Minn. Stat. 62A.047 requires coverage for child health supervision services. Minn. Stat. 62Q.46 PREVENTIVE ITEMS AND SERVICES. § Subdivision 1. Coverage for preventive items and services. (a) "Preventive items and services" has the meaning specified in the Affordable Care Act.	Preventive and wellness services and chronic disease management is an essential health benefit. 45 CFR § 147.130 https://www.law.cornell.edu/cfr/text/45/147.130 An HMO must cover all benefits listed as A or B rating by preventive health task force for adults, children and women without cost sharing. This list changes from year to year, so HMO must review this list on an annual basis. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ Preventive services are covered in the state benchmark plan.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		(b) A health plan company must provide coverage for preventive items and services at a participating provider without imposing cost-sharing requirements, including a deductible, coinsurance, or co-payment. Nothing in this section prohibits a health plan company that has a network of providers from excluding coverage or imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider. (c) A health plan company is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph (a) if the recommendation or guideline is no longer included as a preventive item or service as defined in paragraph (a). Annually, a health plan company must determine whether any additional items or services must be covered without cost-sharing requirements or whether any items or services are no longer required to be covered. (d) Nothing in this section prevents a health plan company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service	

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		to the extent not specified in the recommendation or guideline. (e) This section does not apply to grandfathered plans. Minn. Stat. 62D.095—cost sharing on preventive services. A health maintenance contract may impose a co-payment and coinsurance consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a. Other preventive services required by state law: please see Cancer Screening section, below.	
Pediatric services			
HMOs must cover all medically necessary pediatric services. An enrollee may designate a pediatric provider as primary care provider for a child enrollee. Per MDH network adequacy requirements, all networks must include at least one pediatric specialty hospital in the in-network tier.	All	Minn. Rules 4685.0100, subp. 5 D (below); 4685.0700, subp. 2 Outpatient health services" means **ambulatory care including health supervision, preventive**, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions;	Pediatric services, including oral and vision care is an essential health benefit. If an individual or group plan requires an enrollee to designate a primary care provider, it must allow a pediatric provider as primary care provider. 45 CFR 147.138(a)(2)

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		provision of prescription drugs; and other supportive treatment. 62A.047—child health supervision An HMO must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. 62Q.57 DESIGNATION OF PRIMARY CARE PROVIDER. § Subdivision 1.Choice of primary care provider. (a) If a health plan company offering a group health plan, or an individual health plan that is not a grandfathered plan, requires or provides for the designation by an enrollee of a participating primary care provider, the health plan company shall permit each enrollee to: (1) designate any participating primary care provider available to accept the enrollee; and (2) for a child, designate any participating physician who specializes in pediatrics as the child's primary care provider and is available to accept the child.	

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		(b) This section does not waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of pediatric care. Subd. 2.Notice. A health plan company shall provide notice to enrollees of the provisions of subdivision 1 in accordance with the requirements of the Affordable Care Act.	
Specialty care			
HMOs must cover all medically necessary specialty provider services. In reviewing HMO networks for network adequacy[10], MDH verifies that all specialty providers are included in the network. A waiver is granted in certain circumstances such as lack of available providers.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	Ambulatory patient services is an essential health benefit.
Mental Health Services			

[10] 62D.124, 62K.10

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
HMOs must cover all medically necessary mental health diagnosis and treatment, including inpatient, outpatient, adult and child residential, diagnostics and prescription drugs. Certificates of coverage must include clear statement of benefits, restrictions and limitations and include a statement of mental health parity rights	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; **treatment of mental and emotional conditions**; provision of prescription drugs; and other supportive treatment. State mental health parity 62Q.47 62Q.01 Subd 6a Definition of nonquantitative treatment limitations or NQTLs for mental health parity assessment Coverage of court ordered treatment 62Q.535 Coverage of mental health prescription drugs 62Q.527 Coverage of family therapy for treatment of minor 62D.102	Mental health and substance use disorder services, including behavioral health treatment is an essential health benefit. Mental health parity with medical services is required. A health plan offered by an issuer that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. 45 CFR § 146.136 45 CFR § 147.160 (applies to individual and group plans)

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		Coverage of second opinion 62D.103 Coverage of residential treatment for emotionally disabled children 62A.151 Mental health medical necessity definition 62Q.53	
Substance Use Disorder Services			
HMOs must cover all medically necessary substance use disorder services, including inpatient, outpatient, diagnostic, residential and prescription drugs, including medication assisted treatment services “MAT.” Certificate of coverage must include clear statement of benefits, restrictions and limitations and statement of mental health parity rights, which also applies to substance use disorder services.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; **treatment of alcohol and other chemical dependency**; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment. State mental health/substance use disorder parity law 62Q.47	Substance use disorder services are an essential health benefit.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		Assessment criteria for placement in substance use disorder treatment 62Q.1055 HMOs must contract with providers who participate in chemical dependency treatment accountability plan established by the commissioner of human services. 62Q.135 HMOs must cover chemical dependency treatment provided to an enrollee by the Department of Corrections while the enrollee is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense. 62Q.137	
Inpatient hospital			
Must cover all medically necessary inpatient treatment. May limit only as described in Rule 4685.0700, subp. 3D(3) Coverage includes, but is not limited to hospital charges, inpatient physician charges, anesthesia, diagnostic, lab.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 "In-patient hospital care" means necessary hospital services affording residential treatment to patients. Such services shall include room and board, drugs and medicine, dressings, nursing care, X-rays, and laboratory examination, and other usual and customary hospital services.	Inpatient hospital is an essential health benefit.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
If enrollee changes carriers while confined to hospital, previous carrier must continue to cover expenses until discharge from hospital even if new carrier plan becomes effective during hospitalization. Minn. Rule 2755.0400; 2755.0500		"In-patient physician care" means those health services performed, prescribed or supervised by physicians within a hospital, for registered bed patients therein, which services shall include diagnostic and therapeutic care. Minn. Rule 4685.0700, subp. 1(D) Limitations allowed: Coverage may be limited as follows: For health maintenance contracts issued to a specified group or groups, the coverage may be limited to 365 days of care in a given period of confinement for a condition arising from a single illness or injury, provided that if this coverage is exhausted the benefit must be renewed, or a new period of confinement commenced, upon the occurrence of a separate illness or injury or upon the passage of no more than 90 days without utilization of inpatient hospital care; and provided further, that if an enrollee group rejects in writing the limits of coverage in favor of lesser limits, the coverage may be limited to no less than 180 days, with no more than 90 days between periods of confinement. For individual health maintenance contracts, the coverage may be limited	

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		to 90 days of care in a given period of confinement for a condition arising from a single illness or injury, provided that if this coverage is exhausted the benefit must be renewed or a new period of confinement commenced, upon the occurrence of a separate illness or injury or upon the passage of no more than 90 days without utilization of inpatient hospital care. For inpatient hospital care out of the service area of the health maintenance organization as defined in parts 4685.1010, subpart 1, item B, and 4685.0100, subpart 11, and as required in subpart 2, item B, the coverage may be limited to 60 days of care in each contract year. These provisions relate to the aggregate number of days of both acute care and convalescent care, both of which must be rendered to enrollees by the health maintenance organization Liability of previous carrier when confined to hospital Minn. Rule 2755.0400; 2755.0500	

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
Outpatient hospital			
HMOs must cover all medically necessary outpatient treatment. Coverage includes, but is not limited to outpatient/ambulatory surgical center services, physician services, anesthesia services, lab and diagnostic services.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	Ambulatory patient care is an essential health benefit.
Emergency			
HMOs must cover medically necessary emergency services received from network and non-network providers. Coverage outside of the network is only required for emergency and not routine follow up care. Cost sharing (deductibles, flat fee copays and coinsurance) must be the same for network and non-network providers (including outside the country). However, non-network emergency providers are not	All	62Q.55 "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii), of section 1867(e)(1)(A) of the Social Security Act.	Emergency services is an essential health benefit. 45 CFR § 147.138 Coverage of Emergency Services and Cost Sharing https://www.law.cornell.edu/cfr/text/45/147.138

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
prohibited by law from balance billing enrollees. See 62Q.556.		"Emergency services shall be covered whether provided by participating or nonparticipating providers and whether provided within or outside the health plan company's service area." Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 "Emergency care" means medically necessary care which is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the enrollee in serious jeopardy. 62Q.556 Balance billing by non-network emergency providers is not prohibited by law. HMOs are encouraged to negotiate payment in full with non-network emergency providers but this law does not prohibit balance billing by emergency providers.	
Urgent Care			
HMOs must cover all medically necessary urgent care.	All	Minn. Rules 4685.0100, subp. 5; Urgent care "means medically necessary care which does not meet the definition of emergency care but is needed as soon as possible, usually within 24 hours." Minn. Rule 4685.0100, subp. 16	Ambulatory care, including urgent care is an essential health benefit.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		4685.0700, subp. 2 HMOs must cover all medically necessary outpatient services, including urgent care.	
Prescription Drugs			
HMOs must cover all medically necessary prescription drugs. HMOs may use a formulary consistent with state and federal requirements, but must also have formulary exception process consistent with state and federal law. Drug formulary tiers are allowed. Commonly used tiers include: generic, brand, specialty drugs. If formulary exception is granted, enrollee must pay copay consistent with tier of exception approved drug. If formulary exception is granted for contraceptives, cost-sharing is 0 per ACA requirements. Under ACA, individual and small group plans must cover preventive prescription medications without cost-sharing, such as FDA-approved tobacco cessation drugs and products, aspirin, folic acid, vitamin D, and fluoride supplements.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Comprehensive health maintenance services includes "provision of prescription drugs." Formulary and exception requirements: Minn. Rules 4685.0700, subpart 3(A) A. A health maintenance organization may limit outpatient prescription drug benefits through the use of a formulary. (1) The formulary must be periodically reviewed and updated by physicians and pharmacists to determine that formulary drugs are, at a minimum, safe and effective. (2) The formulary must contain all prescription drugs needed to provide medically necessary care. (3) A health maintenance organization shall promptly grant an exception to the formulary when the formulary drug causes an adverse reaction, when the formulary drug is contraindicated, or	Prescription drugs are an essential health benefit. 45 CFR § 156.122 - Prescription drug benefits. https://www.law.cornell.edu/cfr/text/45/156.122 (a) A health plan does not provide essential health benefits unless it: (1) Subject to the exception in paragraph (b) of this section, covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan; (2) Submits its formulary drug list to the Exchange, the State or OPM; and (3) For plans years beginning on or after January 1, 2017, uses a pharmacy and therapeutics (P&T) committee that meets the following standards. Must have a Pharmacy and Therapeutics Committee and review consistent with regulation.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
Certificate of coverage must clearly specify formulary tiers, cost-sharing, step therapy requirements, and formulary exception criteria and process. Must specify step therapy exception process.		when the prescriber demonstrates that a prescription drug must be dispensed as written to provide maximum medical benefit to the enrollee. (a) A health maintenance organization shall have written guidelines and procedures for granting an exception to the formulary that shall be available to the enrollee and prescriber upon request. 30 days' notice required to enrollees of removal of formulary drugs: 62D.07, subd. 8 Step therapy exception process: 62Q.184 HMOs must have a step therapy exception process consistent with law. Medication management 62Q.676 A pharmacy benefit manager must provide medication management for enrollees taking four or more prescriptions to treat or prevent two or more chronic medical conditions. Mental health drug coverage 62Q.526 Continuity of care for anti-psychotic drugs and mental health drugs removed from formulary and when enrollee changes plans.	Must have formulary exception process consistent with regulation. This regulation applies to individual and small group plans. If formulary drugs are removed during the plan year, HMOs must provide 30 days' notice to enrollees per Minn. Stat. 62D.07, subd. 8.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		Clinical Trial 62D.109 HMOs must provide services for qualifying clinical trials. Prescription eye drops 62A.3095 Coverage for refills of prescription eye drops. Oral chemotherapy drugs 62A.3075 HMOs may not discriminate in cost-sharing between IV and oral chemotherapy drugs. Off label drugs for treatment of cancer 62Q.525 HMOs must cover off label drugs for treatment of cancer per requirements of statute. NEW FOR 2020 62Q.1841 Prohibition on use of step therapy for metastatic cancer Subd. 2.Prohibition on use of step therapy protocols. A health plan that provides coverage for the treatment of stage four advanced metastatic cancer or associated conditions must not limit or exclude coverage for a drug approved by the United States Food and Drug Administration that is on the health plan's prescription drug	

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		formulary by mandating that an enrollee with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with: (1) a United States Food and Drug Administration-approved indication; and (2) a clinical practice guideline published by the National Comprehensive Care Network. 62Q.528 DRUG COVERAGE IN EMERGENCY SITUATIONS. A health plan that provides prescription drug coverage must provide coverage for a prescription drug dispensed by a pharmacist under section 151.211, subdivision 3, under the terms of coverage that would apply had the prescription drug been dispensed according to a prescription.	
Lab and diagnostic			
HMOs must cover all medically necessary lab and diagnostic scans HMOs are allowed to limit scans to participating providers	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, **including diagnostic radiologic service;** therapeutic services for congenital,	Laboratory and diagnostic services are an essential health benefit.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	
Maternity and Newborn Care			
HMOs must cover all medically necessary prenatal care without cost-sharing HMOs must cover all medically necessary inpatient and outpatient maternity care Coverage includes one post-natal home health visit Newborns are covered from date of birth under 62A.042 Direct access to ob/gyn is required under 62Q.52 Must cover breast-feeing support and manual pump in individual and small group plans per ACA requirements Must cover surrogate prenatal and maternity care if the surrogate is enrolled in the plan	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 62A.0411 HMOs must provide coverage of a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn. The health plan shall not provide any compensation or other nonmedical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified in this section. The health plan must also provide coverage for postdelivery care to a mother and her newborn if the duration of inpatient care is less than the minimums provided in this section. Postdelivery care consists of a minimum of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to, parent education,	Maternity and newborn care is an essential health benefit Individual and small group must cover all USPSTF A and B recommendations, including but not limited to: folic acid supplements for women planning or capable of pregnancy; HIV screening for pregnant women, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation; preeclampsia prevention and screening; breastfeeding intervention (including manual pump) and perinatal depression screening. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ The Newborns' and Mothers' Health Protection Act of 1996 requires a minimum inpatient of 48 hours following a vaginal delivery and 96 hours following a cesarean section. This is codified in state law 62A.0411.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four days following the discharge of the mother and her child. 62A.047 HMOs must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. "Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.	
Contraceptives and Sterilization			

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
All HMO plans must cover medically necessary contraceptives as part of comprehensive health maintenance services. Individual and small group plans covered by ACA requirements must cover at least one form of contraception in each of all 18 approved FDA approved methods. Includes OTC drugs like emergency contraception with a prescription. No cost sharing permitted for formulary contraceptive drugs. HMOs must have exception process for drugs not covered on formulary, and if granted for individual and small group, cost sharing must be 0 per ACA requirements. Surgical sterilization is a required benefit for women per ACA requirements. "Religious employers," religiously affiliated non-profit and closely held corporations with objections to covering contraceptives may apply for an exemption. If an exemption is granted for religiously affiliated non-profit or closely held corporation, the HMO must provide contraceptive	All unless group employer qualifies for exemption under 45 CFR 147.131-132.	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 The Managed Care Systems Section has always interpreted contraceptives as a medically necessary required service for the provision of comprehensive health maintenance services. 62Q.14—open access for family planning services 62Q.52 Direct access to routine ob/gyn	Contraceptive services, drugs and devices for women are an essential health benefit. Plans and issuers must cover without cost sharing at least one form of contraception in each of the methods (currently 18) that the FDA has identified for women. This coverage must also include the clinical services, including patient education and counseling, needed for provision of the contraceptive method. The full range of contraceptive methods for women currently identified by the U.S. Food and Drug Administration include: (1) sterilization surgery for women, (2) surgical sterilization via implant for women, (3) implantable rods, (4) copper intrauterine devices, (5) intrauterine devices with progestin (all durations and doses), (6) the shot or injection, (7) oral contraceptives (combined pill), 8) oral contraceptives (progestin only, and), (9) oral contraceptives (extended or continuous use), (10) the contraceptive patch, (11) vaginal contraceptive rings, (12) diaphragms, (13) contraceptive sponges, (14) cervical caps, (15) female condoms, (16) spermicides, and (17) emergency contraception (levonorgestrel), and (18) emergency contraception (ulipristal acetate), and additional methods as identified by the FDA. Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
coverage separately and must notify enrollees of this option for coverage. This separate coverage requirement does not apply to enrollees of group plans by "religious employers." 45 CFR 147.131 45 CFR 147.132 The regulations seeking to broaden these rules to moral exemptions (45 CFR 147.133) have not taken effect due to court challenges. https://www.hhs.gov/about/news/2018/11/07/fact-sheet-final-rules-on-religious-and-moral-exemptions-and-accommodation-for-coverage-of-certain-preventive-services-under-affordable-care-act.html Family planning services and diagnosis of infertility is open access services under Minn. Stat. 62Q.14.			https://www.hrsa.gov/womens-guidelines-2016/index.html HMOs may utilize reasonable medical management methods. HMOs must have a formulary exception process. If provider determines a non-formulary drug is necessary, HMO must cover non-formulary drug without cost-sharing. https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf "Religious employers," religiously affiliated non-profit and closely held corporations with objections to covering contraceptives may apply for an exemption. If an exemption is granted for religiously affiliated non-profit or closely held corporation, the HMO must provide contraceptive coverage separately and must notify enrollees of this option for coverage. This separate coverage requirement does not apply to enrollees of group plans by "religious employers." 45 CFR 147.131 45 CFR 147.132 The regulations seeking to broaden these rules to moral exemptions (45 CFR 147.133) have not taken effect due to court challenges. https://www.hhs.gov/about/news/2018/11/07/fact-sheet-final-rules-on-religious-and-moral-exemptions-and-accommodation-for-coverage-

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
			of-certain-preventive-services-under-affordable-care-act.html Contraceptives FAQs: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf
Home Health Care			
Home health care is a service that can be limited, but not excluded under HMO Rule 4685.0700, subp. 3(C). MDH has historically allowed a visit limit no less than 120 days per year. One postnatal home health care visit is covered without cost-sharing under 62A.0411. Home health care coverage is required up to 120 hours for ventilator dependent enrollee	All	62E.06, Covered services of a qualified plan include: services of a home health agency if the services would qualify as reimbursable services under Medicare. Rule 4685.0700, subp. 3(C): A health maintenance organization may limit home health care services. MDH has historically allowed a visit limit no less than 120 days per year, which was consistent with Medicare coverage requirements. 62A.155 120 hours for ventilator dependent enrollee	Home health care is not expressly listed as an essential health benefit but is covered under outpatient ambulatory care. Home health care is expressly covered in the state benchmark plan up to 120 days per year.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		62A.0411 Postnatal home health visit	
Residential treatment—mental health			
HMOs must cover all medically necessary residential mental health treatment for adults and children	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 HMOs must provide medically necessary inpatient and outpatient mental health services. “In-patient hospital care" includes medically necessary hospital services affording residential treatment to patients. Minn. Stat. 62A.151 HMOs must provide “for the treatment of emotionally disabled children in a residential treatment facility licensed by the commissioner of human services. For purposes of this section ‘emotionally disabled child’ shall have the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities.”	Residential treatment is not expressly specified as an essential health benefit, but mental health and hospitalization are an essential health benefit so medically necessary residential treatment is required. HMOs must cover mental health services at parity with medical services for compliance with federal and state mental health parity laws. This requires consistent coverage for residential treatment.
Residential treatment—substance use disorder			
HMOs must cover all medically necessary residential treatment for substance use disorders.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 HMOs must provide medically necessary inpatient and outpatient substance use disorder services.	Residential treatment is not expressly specified as an essential health benefit, but substance abuse and hospitalization are an essential health benefit so residential is required.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
HMOs may limit providers to those licensed by DHS		"In-patient hospital care" means necessary hospital services affording residential treatment to patients." 62Q.135 No health plan company shall contract with a chemical dependency treatment program, unless the program participates in the chemical dependency treatment accountability plan established by the commissioner of human services. Minn. Rule 4685.1010, subp. 2 E Provider contracting requirements: The health maintenance organization shall contract with or employ sufficient numbers of qualified providers of outpatient mental health and chemical dependency services to meet the projected needs of its enrollees consistent with generally accepted practice parameters. (1) Services for people with alcohol and other chemical dependency problems shall be provided by outpatient treatment programs licensed by the Minnesota Department of Human Services under Minnesota Statutes, sections 245G.01 to 245G.20 and 245G.22, or by hospitals licensed under chapter 4640. (2) Outpatient chemical dependency treatment programs serving	HMOs must cover substance use disorder services at parity with medical services for compliance with federal and state mental health/substance use disorder parity laws. This requires consistent coverage for residential treatment.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		adolescents must meet all of the requirements of the Minnesota Department of Human Services contained in part 9530.6400. (3) Outpatient mental health services shall be provided by licensed psychiatrists, psychologists, social workers, marriage and family therapists, and psychiatric nurses, as appropriate in each case, and by mental health centers and mental health clinics licensed by the Minnesota Department of Human Services under chapter 9520. § (4) The health maintenance organization, either directly or through its contracted mental health or chemical dependency provider, shall have available services that are culturally specific or appropriate to a specific age, gender, or sexual preference, to the extent reasonably possible. If any of these services cannot be provided by licensed providers and programs, the health maintenance organization shall file a request for an exception to the requirements of subitems (1) to (4). A request for an exception shall be considered a filing under part 4685.3300. The health maintenance organization shall submit specific data in support of its request.	

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
Skilled nursing facility			
Coverage for Skilled Nursing Facility is required for medically necessary care consistent with Medicare coverage criteria. Skilled Nursing Facility is not covered for long term care.	All	Minn. Stat. 62E.06 Minimum benefits of qualified plan include: services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare. Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 requires coverage for inpatient care and rehabilitative and habilitative care. Inpatient care means necessary hospital services affording residential treatment to patients. Such services shall include room and board, drugs and medicine, dressings, nursing care, X-rays, and laboratory examination, and other usual and customary hospital services. Inpatient coverage may be limited as follows: For health maintenance contracts issued to a specified group or groups, the coverage may be limited to 365 days of care in a given period of confinement for a condition arising from a single illness or injury, provided that if this coverage is exhausted the benefit must be renewed, or a new period of confinement commenced,	Rehabilitative and habilitative services are essential health benefits under ACA.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		upon the occurrence of a separate illness or injury or upon the passage of no more than 90 days without utilization of inpatient hospital care; and provided further, that if an enrollee group rejects in writing the limits of coverage in favor of lesser limits, the coverage may be limited to no less than 180 days, with no more than 90 days between periods of confinement. For individual health maintenance contracts, the coverage may be limited to 90 days of care in a given period of confinement for a condition arising from a single illness or injury, provided that if this coverage is exhausted the benefit must be renewed or a new period of confinement commenced, upon the occurrence of a separate illness or injury or upon the passage of no more than 90 days without utilization of inpatient hospital care. These provisions relate to the aggregate number of days of both acute care and convalescent care, both of which must be rendered to enrollees by the health maintenance organization	

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
Durable Medical Equipment			
All HMO plans must cover medically necessary DME, orthotics and prosthetics, but may limit the brands and models covered to standard equipment medically appropriate for the condition. Nondurable medical equipment generally is not a required coverage.	All	DME must be covered, but may be limited 4685.0700, subp. 3(B): A health maintenance organization must cover all medically necessary DME, but may limit payment of DME, orthotics, prosthetics to basic model that is medically appropriate. 62Q.66 Definition of DME does not require that it be limited to only what is used in the home. 62Q.67 62Q.67 DISCLOSURE OF COVERED DURABLE MEDICAL EQUIPMENT. § Subdivision 1.Disclosure. A health plan company that covers durable medical equipment shall provide enrollees, and upon request prospective enrollees, written disclosure that includes the information set forth in subdivision 2. The health plan company may include the information in the member contract, certificate of coverage, schedule of payments, member handbook, or other written enrollee communication.	Rehabilitative and habilitative services and devices are an essential health benefit. Therefore, durable medical equipment is included as an EHB.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		Subd. 2.Information to be disclosed. A health plan company that covers durable medical equipment shall disclose the following information: (1) general descriptions of the coverage for durable medical equipment, level of coverage available, and criteria and procedures for any required prior authorizations; and (2) the address and telephone number of a health plan representative whom an enrollee may contact to obtain specific information verbally, or upon request in writing, about prior authorization including criteria used in making coverage decisions and information on limitations or exclusions for durable medical equipment.	
Habilitative services: physical therapy, occupational therapy, speech therapy			
HMOs must cover all medically necessary habilitative therapy. “Habilitative therapy” means therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development.	All	Minn. Rule 4685.0700 Minn. Rule 4685.0100, subp. 5: "Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; **therapeutic services for congenital, developmental, or medical conditions**	Rehabilitative and habilitative services and devices are an essential health benefit.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
Rehabilitative services: physical therapy, occupational therapy, speech therapy			
HMOs must cover all medically necessary rehabilitative therapy.	All	Minn. Rule 4685.0700 Minn. Rule 4685.0100, subp. 5: "Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and **therapeutic services**, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	Rehabilitative and habilitative services and devices are an essential health benefit.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
Speech therapy			
HMOs must cover all medically necessary speech therapy. HMOs cannot exclude speech therapy for stuttering.	All	Minn. Rule 4685.0700 Minn. Rule 4685.0100, subp. 5: “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and **therapeutic services**, including diagnostic radiologic service; **therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development**; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	Rehabilitative and habilitative services and devices are an essential health benefit.
Occupational therapy			
HMOs must cover all medically necessary occupational therapy. Occupational therapy is therapy to help people learn or regain daily activity abilities.	All	Minn. Rule 4685.0700 Minn. Rule 4685.0100, subp. 5: “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions;	Rehabilitative and habilitative services and devices are an essential health benefit.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
		provision of prescription drugs; and other supportive treatment	
Organ Transplant services			
HMOs must cover all medically necessary non-experimental organ transplant services. HMOs can limit coverage to certain providers known as “referral centers.” These are facilities that provide specialized services and expertise for organ transplants. Usual hospital and specialty geographic access requirements may not apply**.**	All	Minn. Rule 4685.0700 Minn. Rule 4685.1010, subp. 1A "Referral centers" means medical facilities that provide specialized medical care such as organ transplants and coronary artery bypass surgery. Examples of criteria the health maintenance organization may use in designating a facility as a referral center are volume of services provided annually and the case mix and severity adjusted mortality and morbidity rates. Referral centers may be located within or outside the health maintenance organization's service area.	Inpatient hospitalization is an essential health benefit.
Hospice			
HMOs must cover hospice services as an alternative to hospitalization when life expectancy is six months or less and enrollee chooses a plan of care focused on palliative and not curative care.	All	Minn. Rule 4685.0700 There are no laws or rules expressly referencing hospice care. However, this falls under provision of comprehensive health maintenance services and is an an alternative to hospitalization when life expectancy is six months or less.	Hospice care is not expressly stated as an essential health benefit but is covered in the Minnesota benchmark plan.

Major Required Covered Services	Markets covered: Individual, small or large group	State law	Federal law
Chiropractic			
HMOs must cover medically necessary services from chiropractors	All	Minn. Rule 4685.0700 Minn. Rule 4685.1010 Outpatient care includes ambulatory care including therapeutic services. 62A.15 Subd. 2.Chiropractic services. All benefits provided by any policy or contract referred to in subdivision 1, relating to expenses incurred for medical treatment or services of a physician must also include chiropractic treatment and services of a chiropractor to the extent that the chiropractic services and treatment are within the scope of chiropractic licensure. This subdivision is intended to provide equal access to benefits for insureds and subscribers who choose to obtain treatment for illness or injury from a doctor of chiropractic, as long as the treatment falls within the chiropractor's scope of practice. This subdivision is not intended to change or add to the benefits provided for in these policies or contracts. See also 10/23/97 MDH Administrative Bulletin.	Ambulatory care and therapeutic services are an essential health benefit. Chiropractic is covered in benchmark plan.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Acupuncture			
HMO large group plans must cover a trial of acupuncture for pain management.	Large group only, not required for individual or small group.	Minn. Rule 4685.0700 Minn. Rule 4685.1010 HMOs must cover therapeutic services. Regulatory history: MCS received enrollee complaints regarding exclusion of acupuncture. MCS determined based on current medical research at the time that acupuncture is safe and effective for some people and a trial of acupuncture should be covered for chronic pain or when other pain management methods are not tolerated. Acupuncture is not a required coverage in individual and small group plans because it is excluded from the benchmark plan. 62D.107 Subdivision 1.Coverage. All benefits provided by a health maintenance contract relating to expenses incurred for acupuncture services that are provided by a physician must also include acupuncture treatment and services of a licensed acupuncture practitioner to the extent that the acupuncture services and treatment are within the scope of acupuncture practitioner licensure. This subdivision ensures equal access to benefits for enrollees who choose to directly obtain treatment for illness and injury from a	Acupuncture is not covered in the benchmark plan

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		licensed acupuncture practitioner, as long as the treatment falls within the scope of practice of the licensed acupuncture practitioner. This subdivision is not intended to change or add to the benefits provided for in these policies or contracts. Subd. 2.Denial of benefits. (a) In the payment of claims for enrollees in this state, no health maintenance organization may deny payment for acupuncture services covered by an enrollee's health maintenance contract if the services are lawfully performed by a licensed acupuncture practitioner. (b) When a health maintenance organization makes a denial of payment claim determination concerning the appropriateness, quality, or utilization of acupuncture services for enrollees in this state performed by a licensed acupuncture practitioner, the determination must be made by, under the direction of, or subject to the review of a licensed acupuncture practitioner. 62A.15, subd. 3b: Subd. 3b.Acupuncture services. (a) This subdivision, subdivision 4, and section 62D.107 may be cited as the Equal Access to Acupuncture Act and as a	

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		memorial to Edith R. Davis, Minnesota's pioneer acupuncturist. (b) All benefits provided by a policy or contract referred to in subdivision 1 relating to expenses for acupuncture services that are provided by a physician must also include acupuncture treatment and services of a licensed acupuncture practitioner to the extent that the acupuncture services and treatment are within the scope of acupuncture practitioner licensure. This subdivision is intended to provide equal access to benefits for insureds and subscribers who choose to directly obtain treatment for illness or injury from a licensed acupuncture practitioner, as long as the treatment falls within the scope of practice of the licensed acupuncture practitioner.	
Amino Acid based Elemental Formula			
All HMOs must cover amino acid based elemental formula when medically necessary for the following conditions: 1. cystic fibrosis; 2. amino acid, organic acid, and fatty acid metabolic and	All	Complaints were received by MCS regarding exclusion of amino acid based formulas. MCS determined coverage was medically necessary.	Not expressly covered as an essential health benefit, but covered in the Minnesota benchmark plan.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
malabsorption disorders; 3. IgE mediated allergies to food proteins; 4. food protein-induced entercolitis syndrome; 5. eosinophilic esophagitis; 6. eosinophilic gastroenteritis; and 7. eosinophilic colitis			
Autism therapies			
All HMO plans must cover diagnosis and basic treatment of autism. Large group plans are required to cover early intensive behavioral and developmental therapies, including applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention.	Large group only	62A.3094 A health plan issued to a large employer, as defined in section 62Q.18, subdivision 1, must provide coverage for the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders, including but not limited to the following: (1) early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention; (2) neurodevelopmental and behavioral health treatments and management; (3) speech therapy; (4) occupational therapy; (5) physical therapy; and (6) medications.	Intensive behavioral and developmental therapies are not a required coverage.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		(b) The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities. (c) The coverage required under this subdivision must include treatment that is in accordance with an individualized treatment plan prescribed by the enrollee's treating physician or mental health professional. (d) A health carrier may not refuse to renew or reissue, or otherwise terminate or restrict, coverage of an individual solely because the individual is diagnosed with an autism spectrum disorder. (e) A health carrier may request an updated treatment plan only once every six months, unless the health carrier and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances. (f) An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.	

Other Services Required by Law or Rules:	**Markets Covered**	**State law**	**Federal Law**
Bariatric Surgery			
Bariatric surgery coverage is required for large group only, not individual or small group. HMOs can require enrollees to access services at "referral centers." These are facilities that provide specialized services and expertise for bariatric surgery. Usual hospital and specialty geographic access requirements may not apply.	Large group only	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 "In-patient hospital care" means necessary hospital services affording residential treatment to patients. Such services shall include room and board, drugs and medicine, dressings, nursing care, X-rays, and laboratory examination, and other usual and customary hospital services." Many HMO plans excluded bariatric surgery as not medically necessary or unproven. MCS determined that bariatric surgery is medically necessary standard of care for qualifying enrollees and covered under "comprehensive health maintenance services." Prior to ACA, all HMO plans were required to cover bariatric surgery. However, bariatric surgery was not included as an essential health benefit, and was not covered in the benchmark plan. For purposes of market consistency, MCS does not require this benefit for individual or small group HMO products covered under ACA and Minnesota Statutes, chapter 62K. Coverage of bariatric surgery is currently only required for large group plans.	Bariatric surgery is not included as an essential health benefit or in the Minnesota benchmark plan. Therefore, coverage is not required for individual and small group plans covered by the ACA and Minnesota Statutes, chapter 62K.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Cancer screening			
HMOs must cover all medically necessary, standard or care cancer screening without cost sharing	All	Minn. Rule 4685.0700 HMOs must cover all medically necessary preventive care. 62Q.50 Prostate cancer screening A health plan must cover prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. 62A.30 Routine cancer screenings, including ovarian, cervical, colorectal and breast cancer screening: Every policy, plan, certificate, or contract referred to in subdivision 1 that provides coverage to a Minnesota resident must provide coverage for routine screening procedures for cancer and the office or facility visit, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer as defined in subdivision 3, pap smears, and colorectal screening tests for men and women, when ordered or provided by a physician in accordance with the standard practice of medicine. Subd. 3.Ovarian cancer surveillance tests. For purposes of subdivision 2: (a) "At risk for ovarian cancer" means: (1) having a family history:	ACA requires coverage without cost-sharing of all USPTFS A and B recommendations for cancer screening, including but not limited to: BRCA risk assessment and genetic counseling/testing; Breast cancer screening and preventive medications; Cervical cancer screening; Colorectal cancer screening; Lung cancer screening; Skin cancer behavioral counseling; https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ BCRA testing FAQs: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		(i) with one or more first- or second-degree relatives with ovarian cancer; (ii) of clusters of women relatives with breast cancer; or (iii) of nonpolyposis colorectal cancer; or (2) testing positive for BRCA1 or BRCA2 mutations. (b) "Surveillance tests for ovarian cancer" means annual screening using: (1) CA-125 serum tumor marker testing; (2) transvaginal ultrasound; (3) pelvic examination; or (4) other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute. § Subd. 4.Mammograms. (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46. (b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:	

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		(1) having a family history with one or more first- or second-degree relatives with breast cancer; (2) testing positive for BRCA1 or BRCA2 mutations; (3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or (4) having a previous diagnosis of breast cancer. (c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L. (d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020. (e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer. 62A.154 No denial, exclusions or limitations allowed for DES related conditions	

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Cancer treatment			
HMOs must cover all medically necessary cancer treatment, qualifying off-label drugs and qualifying clinical trials.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700 Minn. Stat. 62Q.525 Off-label drugs: HMOs may not exclude coverage of a drug for the treatment of cancer on the ground that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard reference compendia or in one article in the medical literature, as defined in subdivision 2. Minn. Stat. 62Q.526 Must cover qualified clinical trials as defined in the statute. 62A.3075 HMOs must cover oral chemotherapy drugs and may not discriminate in cost-sharing between oral chemo and IV chemo drugs. 62Q.1841 Prohibition on use of step therapy for metastatic cancer Subd. 2.Prohibition on use of step therapy protocols. A health plan that provides coverage for the treatment of stage four advanced metastatic cancer or associated conditions must not limit or exclude coverage for a drug approved	Cancer treatment is an essential health benefit.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		by the United States Food and Drug Administration that is on the health plan's prescription drug formulary by mandating that an enrollee with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with: (1) a United States Food and Drug Administration-approved indication; and (2) a clinical practice guideline published by the National Comprehensive Care Network.	
Clinical Trials			
HMOs must cover approved clinical trials	All	Minn. Stat. 62Q.526 HMOs must cover approved clinical trials as defined by statute: health plan company that offers a health plan to a Minnesota resident may not: (1) deny participation by a qualified individual in an **approved clinical trial**; (2) deny, limit, or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or (3) discriminate against an individual on the basis of an individual's participation in an approved clinical trial. Minn. Stat. 62D.109 Disclosure of coverage to enrollee:	Federal regulations require individual and group plans to cover participation in clinical trials: 42 U.S.C.A. § 300gg https://www.law.cornell.edu/uscode/text/42/300gg-8

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		A health maintenance organization must inform an enrollee who is a participant in a clinical trial upon inquiry by the enrollee that coverage shall be provided as required under the enrollee's health maintenance contract or under state or federal rule or statute.	
Cleft lip/palate			
HMOs must cover treatment for cleft lip/palate.	All	Minn. Rule 4685.0700 Minn. Stat. 62A.042, subd. 1(b) HMOs must cover inpatient and outpatient expenses arising from medical and dental treatment up to the limiting age for coverage of the dependent, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital	Covered in Minnesota benchmark plan

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		condition of cleft lip and cleft palate shall not be covered under this provision.	
Dental care—adult			
HMOs are NOT required to cover adult dental care, except for treatment of temporomandibular joint disorder and craniomandibular disorder, or if dental treatment is required to treat an underlying medical condition.	None	4685.0700, subp. 4 permissible exclusions include dental. 62A.043 All HMO plans must provide coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder.	Adult dental care is not required by ACA.
Dental care—pediatric			
Pediatric dental is required for individual and small group plans offered on and off MNSure. Pediatric dental may be offered embedded with the medical benefits, or as a stand-alone dental plan. All HMO plans must cover hospitalization and anesthesia for dental care for a child under age five, or an enrollee who is severely disabled, or has a medical condition that requires hospitalization and general anesthesia for dental treatment.	Individual and small group only All plans must cover medically necessary hospitalization and anesthesia as required by statute.	62A.308 a) A health plan included in subdivision 1 must cover anesthesia and hospital charges for dental care provided to a covered person who: (1) is a child under age five; or (2) is severely disabled; or (3) has a medical condition and who requires hospitalization or general anesthesia for dental care treatment. A health carrier may require prior authorization of hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions. (b) A health plan included in subdivision 1 must also provide coverage for general anesthesia and treatment rendered by a dentist for a medical	Pediatric dental care is an essential health benefit. Pediatric dental can be embedded in the medical plan or offered through a stand-alone dental plan. The pediatric dental benchmark is the FEDVIP plan. A qualified dental plan must cover all the services covered in this plan: http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf As of plan year 2020, there were no HMOs offering stand-alone dental plans for sale on MNSure. Cost-sharing rules for stand-alone dental plans:

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		condition covered by the health plan, regardless of whether the services are provided in a hospital or a dental office.	45 CFR 156.150 https://www.law.cornell.edu/cfr/text/45/156.150
Diabetes			
HMOs must cover all medically necessary treatment, supplies and education for treatment of diabetes.	All	Minn. Stat. 62A.3093 COVERAGE FOR DIABETES. § Subdivision 1.Required coverage. A health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must provide coverage for: (1) all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and (2) diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage must include persons with gestational, type I or type II diabetes. Coverage required under this section is subject to the same deductible or coinsurance provisions applicable to the plan's hospital, medical expense, medical equipment, or prescription drug benefits. A health carrier may not reduce or eliminate coverage due to this requirement.	Diabetes coverage is an essential health benefit. Preventive services required without cost-sharing include screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		Subd. 2.Medicare Part D exception. A health plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), is not subject to the requirements of subdivision 1, clause (1), with respect to equipment and supplies covered under the Medicare Part D Prescription Drug program, whether or not the covered person is enrolled in a Medicare Part D plan. This subdivision does not apply to a health plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), that was in effect on December 31, 2005, if the covered person remains enrolled in the plan and does not enroll in a Medicare Part D plan. 62Q.48 Cost-sharing for Prescription Insulin HMO plans that impose cost-sharing requirements on prescription insulin drug shall limit the total amount of cost-sharing that an enrollee is required to pay at point of sale, including deductible payments and the cost-sharing amounts charged once the deductible is met at an amount that does not exceed the net price of the prescription insulin drug.	
Eye exam-adult			

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Large group plans must cover routine adult eye exams. Individual and small group plans are not required to cover adult eye exams.	Only large group plans must cover adult eye exams.	HMO rules 4685.0700 and 4685.0100 historically required all HMO plans to cover routine adult eye exams. When ACA was enacted, the laws and regulations did not require coverage of routine adult eye exams. For purposes of market consistency with health insurance companies and consistency of coverage on and off the Exchange, individual and small group HMO plans are not required to cover routine adult eye exams, but may cover routine eye exams as an optional benefit. Large group plans are still required to cover routine adult eye exams. 62A.15 requires plans that covering eye exams cover routine services from optometrists.	Routine adult eye exams are not an essential health benefit and not a required coverage under ACA.
Eye exam and eyewear--pediatric			
All HMOs must cover routine pediatric vision screening without cost-sharing. Coverage is required for routine eye exams. Pediatric eyewear is required for individual and small group plans governed by ACA requirements.	All plans must cover pediatric visions screening and eye exams. Large group plans are exempt from pediatric eyewear coverage requirement.	Minn. Rule 4685.0700 requires all plans to cover routine pediatric vision screening and exams.	Pediatric vision screening is an essential health benefit and must be covered without cost-sharing. https://www.healthcare.gov/preventive-care-children/ The USPSTF recommends vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors. The pediatric vision services covered as an essential health benefit include annual examinations, glasses (both lenses and

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
			frames), or contact lenses instead of glasses. HMOs can limit coverage of eyewear to standard frames.
Gender dysphoria services			
HMOs must cover all medically necessary gender dysphoria services. Determination of medical necessity and prior authorization protocols for gender dysphoria-related treatment must be based on the most recent, published medical standards set forth by nationally recognized medical experts in the transgender health field Gender reassignment exclusion not allowed. May not discriminate in provision of covered services based on gender identity. There must be a statement of non-discrimination in certificate of coverage that HMO does not discriminate based on gender identity	All	MDH/Commerce Admin bulletin: http://mn.gov/commerce-stat/pdfs/bulletin-insurance-2015-5.pdf	OCR nondiscrimination regulations: 45 CFR Part 92: https://www.law.cornell.edu/cfr/text/45/part-92 A "covered entity" shall treat individuals consistent with gender identity, except that a covered entity may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth is different. Whether a sex-specific recommended preventive service that is required to be covered without cost sharing under PHS Act section 2713 and its implementing regulations is medically appropriate for a particular individual is determined by the individual's attending provider. Q&A 5: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Genetic testing			
Routine, medically necessary, standard of care and non-experimental genetic testing is covered if it will impact treatment or reproductive options.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Covered under comprehensive health maintenance services.	Not expressly listed as an EHB, but lab services and preventive services are an EHB. BRCA testing: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf
Hearing aids			
All HMO plans must cover hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed. Many HMO plans also cover cochlear implants when medically necessary.	All	62Q.675 All HMO plans must cover hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed.	Not an essential health benefit, but covered in the Minnesota benchmark plan.
Lyme disease			
All HMO plans must cover diagnosis and medically necessary, standard of care treatment of Lyme disease.	All	62A.265	Coverage of ambulatory care and testing is an essential health benefit. Covered in the Minnesota benchmark plan.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Mammography			
All HMO plans must cover routine preventive mammography, including 3D mammography as required by 62A.30.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Minn. Stat. 62A.30 Subd. 4.Mammograms. (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46. (b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means: (1) having a family history with one or more first- or second-degree relatives with breast cancer; (2) testing positive for BRCA1 or BRCA2 mutations; (3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or	Mammography is an essential health benefit.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		(4) having a previous diagnosis of breast cancer. (c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L. (d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020. (e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.	
Orthognathic Surgery			
Orthognathic surgery is surgery to realign the maxillofacial skeletal structures with each other and with the other craniofacial structures. Orthognathic surgery is required if medically necessary for treatment of temporomandibular joint disorder and craniomandibular disorder.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Minn. Stat. 62A.043 Required coverage for temporomandibular joint disorder and craniomandibular disorder	Orthognathic surgery is not specifically listed as an essential health benefit.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
PANS/PANDAS			
All HMOs must cover treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).	All	62A.3097 Subd. 3.Required coverage. Every health plan included in subdivision 2 must provide coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments that must be covered under this section must be recommended by the insured's licensed health care professional and include but are not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.	Not specifically listed as an essential health benefit.
PKU			
All HMO plans must provide coverage for special dietary treatment for phenylketonuria when recommended by a physician.	All	Minn. Stat. 62A.26 Subd. 2.Required coverage. Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1985, must provide coverage for special dietary treatment for phenylketonuria when recommended by a physician.	Not an essential health benefit, but covered in Minnesota benchmark plan.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Port wine stain			
All HMO plans must cover elimination or maximum feasible treatment of port-wine stains for any covered person who is a Minnesota resident.	All	62A.304 Subd. 2.Required coverage. Every health plan included in subdivision 1 must cover elimination or maximum feasible treatment of port-wine stains for any covered person who is a Minnesota resident. No health carrier may reduce or eliminate coverage due to this requirement. Subd. 3.Rate increases prohibited. The commissioner of commerce shall not approve any rate increases due to coverage required under subdivision 2. No health maintenance organization, as defined in chapter 62D, shall increase rates due to coverage required under subdivision 2.	Not an essential health benefit, but covered in the Minnesota benchmark plan.
Reconstructive Surgery			
All HMO plans must cover medically necessary reconstructive surgery.	All	Minn. Stat. 62A.25 Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a	Medically necessary reconstructive surgery is covered under ambulatory, surgery and inpatient benefits. Medically necessary reconstructive surgery is covered in the Minnesota benchmark plan. The Women's Health Cancer Rights Act requires coverage: All stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment of physical

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		functional defect as determined by the attending physician. (b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to reconstructive breast surgery following mastectomies. In these cases, coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician. (c) Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient.	complications of all stages of the mastectomy, including lymphedema.
Telemedicine			
HMO plans must cover qualified telemedicine services.	All	Minn. Stat. 62A.672 Subdivision 1.Coverage of telemedicine. (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.	Not an essential health benefit, but typically covered in all HMO plans.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		(b) Nothing in this section shall be construed to: (1) require a health carrier to provide coverage for services that are not medically necessary; (2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or (3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service. Subd. 2.Parity between telemedicine and in-person services. A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or	

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
		contact between a licensed health care provider and a patient. § Subd. 3.Reimbursement for telemedicine services. (a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider. (b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.	
Temporomandibular joint and craniomandibular disorder			
All HMO plans must provide medically necessary coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder.	Yes	Minn. Stat. 62A.043 All HMO plans must provide coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage shall be the same as that for	The Minnesota benchmark plan includes coverage for temporomandibular joint disorder and craniomandibular disorder.

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Orthodontia and orthognathic surgery that is medically necessary to treat temporomandibular joint disorder and craniomandibular disorder is included.		treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist. .	
Tobacco Cessation Treatment			
All HMO plans must cover tobacco cessation consistent with USPSTF and ACA guidelines.	All	Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Prior to passage of ACA, MDH required all HMOs to cover tobacco cessation drugs as part of medically necessary preventive care and provision of medically necessary prescription drugs.	Required preventive care under ACA. Plans must cover: 1. Screening for tobacco use; and, 2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for: (a) Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and (b) All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1

Other Services Required by Law or Rules:	Markets Covered	State law	Federal Law
Vision therapy			
Large group plans must cover vision therapy/orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements. Coverage is may be limited to 10 training visits and 5 follow-up eye exams per year.	Large group only	Coverage requirements based on complaints received by MDH. Limited vision therapy is considered medically necessary and supported by medical literature.	Not required under ACA.
Wigs			
All HMO plans must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.	All	Minn. Stat. 62A.28 Subd. 2.Required coverage. Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1987, must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata. The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.	Covered in benchmark plan.

Exclusions and Limitations Allowed by Law[11]			
Abortion			
HMO plans are only required to cover abortion in cases of rape, incest or if mother's life is in danger.	All	Minn. Stat. 62D.02, subd. 7 Minn. Stat. 145.414	The Hyde amendment prohibits coverage of abortion in individual on exchange products unless carriers follow steps outlined in this bulletin: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf 45 CFR 156.280 https://www.law.cornell.edu/cfr/text/45/156.280 Section 1303(D) of the Affordable Care Act requires that the Exchange must offer at least one product that does not include abortion coverage; Exchange SBCs for individual plans must disclose abortion coverage.
Appetite suppressants			
Prescription appetite suppressants may be excluded if they are not determined to be safe and effective.	All	HMO rules allow HMOs to make determinations of drug formulary selection. Formularies must include all medically necessary drugs.	None
Cosmetic services (does not exclude required reconstructive surgery services)			
HMOs are not required to cover cosmetic services.	All	4685.0700, subp. 4B	None

[11] These services are not required to be covered under Minnesota HMO laws or rules. Exclusion, lifetime limit, visit limits are allowed on these service.

Exclusions and Limitations Allowed by Law[11]			
Custodial Care			
HMOs may exclude custodial care.	All	4685.0700, subp. 4G	None
Dental services			
HMOs may excluded adult dental services unless required for treatment of a covered underlying medical condition. Pediatric dental must be offered for individual and small group plans.	All except individual and small group must offer pediatric dental coverage	4685.0700, subp. 4C	Pediatric dental is an essential health benefit.
Experimental/Unproven treatment			
HMOs may exclude experimental, investigative and unproven treatment. The certificate of coverage must clearly disclose the standard for exclusion stated in Minnesota Rule 4685.0700, subpart 4F.	All	Minn. Rule 4685.0700, subpart 4F: A drug, device, medical treatment, diagnostic procedure, technology, or procedure that is experimental, investigative, or unproven as defined in part 4685.0100, subpart 6a. The health maintenance organization shall make its determination of experimental, investigative, or unproven based upon a preponderance of evidence after the examination of the following reliable evidence, none of which shall be determinative in and of itself: (1) whether there is final approval from the appropriate government regulatory agency, if approval is required;	

Exclusions and Limitations Allowed by Law[11]			
		(2) whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and (3) whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these providers	
Eyewear			
An HMO may exclude adult eyewear.	Individual and small group must cover pediatric eyewear	4685.0700, subpart 4E	ACA requires coverage of pediatric eyewear
Infertility treatment			
Diagnosis of infertility is required; treatment of infertility is not required except to treat an underlying medical condition for purposes other than to achieve fertility.	None		

Exclusions and Limitations Allowed by Law[11]			
Surrogate pregnancy—if the surrogate is covered under plan, all pregnancy related services of the surrogate must be covered. HMOs are not allowed to exclude pregnancy coverage based upon the reason for the pregnancy or surrogate status.			
Medical marijuana			
Medical marijuana is not required to be covered by HMOs.	None	There is no law requiring HMOs to cover therapeutic marijuana. See 152.21 THC THERAPEUTIC RESEARCH ACT.	
Military—injuries received while on military duty to extent coverage is available elsewhere			
HMOs may exclude military injuries to extent coverage is available through military coverage.	None	4685.0700, subpart 4H	
Non-emergency Ambulance			
HMOs may exclude nonemergency ambulance services and special transportation services, except as provided by Minnesota Statutes, section 62J.48. HMOs must cover emergency and medically necessary ambulance.	None	4685.0700, subpart 4D	
Sexual dysfunction drugs			

Exclusions and Limitations Allowed by Law[11]			
Drugs for treatment of sexual dysfunction are not required to be covered by HMOs.	None		