COMMERCE DEPARTMENT

Self-Insured Political Subdivision Compliance Demonstration for Certification under Minnesota Statutes §471.617 Nongrandfathered Plan(s)

Employer Name:

Applicable Plan Year:

Employer Address:

Plan Representative Name and Title:

Plan Representative e-mail and phone:

Third Party Administrator (TPA):

TPA Representative Name and Title:

TPA Representative e-mail and phone:

Name of Plan(s) Offered:

I have researched the compliance topics cited in this document and I certify that the information provided in the pages that follow are true to my knowledge. If there was any compliance concerns over the coverage the plan offers, I have made note of those concerns in the attachments provided.

Signature		Date:	

Minnesota Statutes §471.617 states that a statutory or home rule charter city, county, school district, or instrumentality thereof may self-insure for employee health benefits if the entity has more than 100 employees. However, this statute requires that these plans provide all benefits that are required of group health insurance policies and that these plans must be filed and certified by the Department of Commerce before they are issued or delivered to any person in this state. As of January 1, 2018, "qualified plan" requirements were changed under Minnesota Statutes section 62E.05 to instead reference the requirements of the Affordable Care Act. This document's purpose is to allow entities subject to 471.617 to file for certification under the revised requirements for plan years that begin on or after January 1, 2018. This form is applicable for nongrandfathered plans; a similar form for grandfathered plans is available from the Department of Commerce website.

Affordable Care Act Federal Requirements (Department of Labor)

The attestation signifies compliance with the full regulation cited, not just the summary provided.

29 CFR 2590.711 - Standards relating to benefits for mothers and newborns

The plan provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn that does not restrict benefits for the stay to less than 48 hours following a vaginal delivery and 96 hours following a cesarean section.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2704 - Prohibition of preexisting condition exclusions

The plan does not impose any preexisting condition exclusions.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2708 - Prohibition on waiting periods that exceed 90 days

The plan does not apply any waiting periods that exceeds 90 days. A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the plan can become effective.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2711 - No lifetime or annual limits

With the exception of benefits that are not essential health benefits in Minnesota, the plan does not have any lifetime or annual limits on the dollar amount of covered benefits for any enrollee, whether provided in-network or out-of-network. For information on Minnesota's essential health benefit benchmark, visit: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/minnesota-ehb-benchmark-plan.pdf

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2705 - Prohibiting discrimination against participants and beneficiaries based on a health factor

The plan does not discriminate against employees and their beneficiaries based on a health condition.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2712 - Rules regarding rescissions

The plan does not rescind coverage with respect to an enrollee once the individual is covered under the plan, unless the individual performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the plan.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2713 - Coverage of preventive health services

The plan provides 100% (no cost sharing) coverage for in-network preventive health services as required by the following authorities and their promulgated guidances:
U.S. Preventive Services Task Force:
http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
American Academy of Pediatrics:
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
Health Resources & Services Administration Women's Preventive Services Guidelines:
https://www.hrsa.gov/womensguidelines2016/index.html

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2714 - Eligibility of children until at least age 26

The plan makes dependent coverage to children available until attainment of age 26.

☐ Attested

☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as no child dependent coverage is available to any employees

29 CFR 2590.715-2715 - Summary of benefits and coverage and uniform glossary

The plan provides a written summary of benefits and coverage (SBC) for each benefit package without charge to individuals interested in the plan. The plan makes the uniform glossary available to participants and beneficiaries.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2719 - Internal claims and appeals and external review processes

The plan follows the requirements for internal claims and appeals and external review processes for group health plans as set forth in 29 CFR 2590.715-2719.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.715-2719A - Patient protections

If the plan requires or provides for designation by an enrollee of a participating primary care provider, then the plan must permit each enrollee to designate any participating primary care provider who is available to accept the participant or beneficiary. In such a case, the plan must inform each enrollee of the terms of the plan regarding designation of a primary care provider. The plan does not require authorization or referral in the case of a female enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable as the plan does not require designation of a primary care provider

The plan provides coverage for emergency services without the need for any prior authorization, even if the emergency services are provided on an out-of-network basis, without regard to whether the provider furnishing the emergency services is a participating network provider with respect to the services. If the emergency services are provided out-of-network, the plan does not impose any administrative requirement or limitation that is more restrictive than the requirements or limitations that apply to emergency services received from an in-network provider. Copays and coinsurance for out-of-network emergency services cannot exceed the parameters imposed for in-network services, though the out-of-network deductible and Out of Pocket Maximum can be applied. Section 1867 of the Social Security Act's definition for emergency medical conditions must be met for this purpose, along with its' prudent layperson standard, which is also referred to as the EMTALA standard (rather than a hindsight application of whether the situation was not an emergency).

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

Public Health Service Act Section 2707(b) guidance on Out of Pocket Maximum Limits

The plan's self-only (that is, single coverage) Maximum Out of Pocket Limit is less than or equal to the self-only limit set under section 1302(c)(1) of the Affordable Care Act for the plan year attested.
The plan's non-self-only (that is, family coverage) Maximum Out of Pocket Limit is less than or equal to the non-self-only limit set under section 1302(c)(1) of the Affordable Care Act for the plan year attested. Also, the self-only limit is also met for each individual in the family.

All in-network cost sharing is considered in terms of meeting compliance with the limits set under section 1302(c)(1), including the drug plan's cost sharing.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

29 CFR 2590.712 - Parity in mental health and substance use disorder benefits

The plan provides both and mental health or substance use disorder benefits at parity with medical/surgical benefits as under paragraph (b)(2), (b)(3), or (b)(5) of 29 CFR 2590.712.

☐ Assumed compliant based on equal cost sharing parameters and reliance on third party administrator's assurances on passage of complex quantitative and nonquantitative tests.

☐ Attested; complex quantitative and nonquantitative testing performed by _____ for the plan year 201_. Cost sharing and nonquantitative changes since that plan year have not been material. Demonstration of testing results is available upon request. Cost sharing testing under the quantitative parity analysis was passed for all six required classifications. Nonquantitative testing at a minimum included testing of prior authorization, concurrent review, retrospective review, claims and coding edits, medical necessity criteria, provider reimbursement, and network access. https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act

☐ Not Fully Compliant; the deviation and remediation plan is provided on Attachment ___

State Requirements Applicable to Self-Insured Political Subdivision Major Medical Plans

Below is a summary description of the major statutes affecting self-insured political subdivision's major medical health plans in terms of regulatory plan compliance, as required under Minnesota Statutes §471.617, subdivision 1 ("*Any self-insurance plan shall provide all benefits which are required by law to be provided by group health insurance policies.")*. It is highly recommended that plan sponsors review the full text of the specific statutes and the caveats and exceptions therein, especially when situations arise relating to a specific statute. For the full statutes in original form, please visit the Minnesota Revisor website at https://www.revisor.mn.gov/statutes/**.**

471.617 SELF-INSURANCE OF EMPLOYEE HEALTH BENEFITS.

Aside from the requirement that the plan provides all benefits which are required by law to be provided by group health insurance policies (which is the purpose of many of the attestations that follow), there are several other key requirements in this statute, which enables governmental employers to accept employees' health claims risk directly.

- The employer has more than 100 employees, or participates in a joint risk pool under Minnesota Rules chapter 2785.
- If the plan covers fewer than 1,000 employees, it must have an appropriate level of stop loss insurance that takes into account the number of covered persons. The stop loss insurance must cover all claims.

- The plan must reserve an appropriate amount of funds to cover the estimated cost of claims that have been incurred but not yet paid.
- A parent or legal guardian of a minor is authorized to act on behalf of the minor in the disclosure of a record.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

471.61 GROUP BENEFITS FOR OFFICERS, EMPLOYEES, RETIREES.

The plan allows former employees and their dependents to continue to participate indefinitely in the plan that the employee participated in immediately before retirement if the former employee is receiving a disability benefit or an annuity from a Minnesota public pension plan, or has met age and service requirements necessary to receive an annuity from such a plan. Until the former employee reaches age 65, the former employee and dependents must be pooled in the same group as active employees unless the former employee is enrolled in Medicare due to disability. A former employee may receive dependent coverage only if the employee received dependent coverage immediately before leaving employment. The plan or employer notifies employees before termination of employment of the options available and of the deadline for electing to continue to participate.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

471.611 RETIREES' HEALTH INSURANCE BENEFITS.

If the plan makes payments for retired employees, the cost of those benefits shall be accounted for in accordance with generally accepted accounting principles. Provision of these benefits must be approved, as a separate action, by the governing body of the employing governmental unit. If the plan funds all or a part of the cost of health care benefits for a retired employee, the plan must provide for coverage to be coordinated with Medicare.

Note: the generally accepted accounting principal for governmental retiree benefits is generally *Statement No. 75 of the Governmental Accounting Standards Board Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* and the plan may need the assistance from an actuary qualified to perform this work.
http://www.gasb.org/jsp/GASB/Document_C/DocumentPage?cid=1176166144750&acceptedDisclaimer=true

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable as the plan does not fund any part of retired employees' coverage

62A.03 GENERAL PROVISIONS OF POLICY

The plan includes coverage for treatments by all licensed practitioners of the healing arts unless the plan specifically states the practitioners whose services are covered. However, the plan must cover any service which is in the lawful scope of practice of a duly licensed osteopathic physician, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15 subdivision 3a on an equal basis to that of the service is performed by a medical doctor.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.041 MATERNITY BENEFITS

The plan provides the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women. If an unmarried enrollee is a parent of a dependent child, the plan provides the same coverage for that child as that provided for the child of a married employee choosing family coverage if the enrollee elects family coverage. The plan includes maternity benefits in the same manner as any other illness.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.0411 MATERNITY CARE

The plan provides maternity benefits consistent with other coinsurance, co-payment, deductible, and related contract terms, 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 plan does 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 plan provides coverage for post-delivery care to a mother and her newborn if the duration of inpatient care is less than the minimums provided in this section. Post-delivery 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, 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.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.043 DENTAL AND PODIATRIC COVERAGE

If the plan provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist or podiatrist, the plan shall provide benefits for such services whether performed by a duly licensed physician, dentist or podiatrist. The plan must specifically provide coverage for surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD). Coverage shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.044 PAYMENTS TO GOVERNMENTAL INSTITUTIONS

The plan does not contain any provisions or operational processes that would exclude, deny, or prohibit payments for covered and authorized services rendered or paid by a hospital or medical institution owned or operated by the federal, state, or local government, including correctional facilities, or practitioners therein in any instance wherein charges for such services are imposed. The unit of government operating the institution may maintain an action for recovery of such charges.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.046 COORDINATION OF BENEFITS.

The plan does not deny coverage or payment of the amount it owes as a secondary payor solely on the basis of the failure of the primary coverage payor to pay for those services. The coordination of benefits method may coordinate benefits to prohibit greater than 100 percent coverage when an enrollee is covered by both an individual and a group contract, but benefits coordinated under this paragraph must provide for 100 percent coverage and follow Minnesota Rules chapter 2742. When a covered person's other coverage is Medicare or TRICARE, the plan must determine primacy and coordinate benefits in accordance with the Medicare Secondary Payor or TRICARE provisions of federal law. If the plan is advised by a covered person that all health plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account, the primary plan's deductible is not an allowable expense, except for preventive claims that are not subject to the deductible.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.049 LIMITATIONS ON PREAUTHORIZATIONS: EMERGENCIES

The plan does not contain a provision that makes a person ineligible to receive full benefits because of failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.095 SUBROGATION CLAUSES REGULATED

The plan's subrogation clause provides that it applies only after the covered person has received a full recovery from another source. The subrogation clause provides that the plan's subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the covered person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the health carrier is separately represented by an attorney. If the health carrier is separately represented by an attorney, the health carrier and the covered person, by their attorneys, may enter into an agreement regarding allocation of the covered person's costs, disbursements, and reasonable attorney fees and other expenses. If the health carrier and covered person cannot reach agreement on allocation, the health carrier and covered person shall submit the matter to binding arbitration. Nothing in this section shall limit a health carrier's right to recovery from another source which may otherwise exist at law. For the purposes of this section, full recovery does not include payments made by a health plan to or for the benefit of a covered person. **Also, for purposes of satisfying regulatory concerns regarding misleading and deceptive language and practices under 62A.02 subd. 3, the plan must not list, or refer in any way, subrogated claims as an exclusion, excluded benefit, etc.**

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.15 COVERAGE OF CERTAIN LICENSED HEALTH PROFESSIONAL SERVICES

The plan includes services of a chiropractor to the extent that the services are covered by the plan (for example, if delivered by a medical doctor) and fall within the scope of chiropractic licensure. Similarly, the plan must include services of a of acupuncture practitioner to the extent that the services are covered by the plan and fall within the scope of acupuncture practitioner licensure.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.153 OUTPATIENT MEDICAL AND SURGICAL SERVICES

The plan specifically provides coverage for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital. Coverage must be on the same basis as coverage provided for the same service in a hospital.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.155 COVERAGE FOR SERVICES PROVIDED TO VENTILATOR-DEPENDENT PERSONS

If the plan provides coverage for services provided by a home care nurse or personal care assistant to a ventilator-dependent person in the person's home, it must provide coverage for up to 120 hours of services provided by a home care nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable as the plan does not cover services provided by a home care nurse or personal care assistant to a ventilator-dependent person in the person's home

62A.25 RECONSTRUCTIVE SURGERY

(a) The plan provides 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 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. Coverage may be subject to annual deductible, co-payment, and coinsurance provisions as

may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.26 COVERAGE FOR PHENYLKETONURIA TREATMENT

The plan provides coverage for special dietary treatment for phenylketonuria when recommended by a physician.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.265 COVERAGE FOR LYME DISEASE

The plan provides coverage for treatment of diagnosed Lyme disease. The plan does not impose a special deductible, co-payment, waiting period, or other special restriction on treatment for Lyme disease that is not applied to non-preventive treatment in general.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.28 COVERAGE FOR SCALP HAIR PROSTHESES

The plan provides 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 cost-sharing requirements that apply to similar types of items under the plan and is not limited to less than one prosthesis per year.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.30 COVERAGE FOR DIAGNOSTIC PROCEDURES FOR CANCER

The plan provides 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, 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. "At risk for ovarian cancer" means: (1) having a family history: (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. "Surveillance tests for ovarian cancer" means annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examination, or other proven ovarian cancer screening tests currently being evaluated by the FDA or by the National Cancer Institute.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.304 COVERAGE FOR PORT-WINE STAIN ELIMINATION

The plan covers elimination or maximum feasible treatment of port-wine stains.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.307 PRESCRIPTION DRUGS; EQUAL TREATMENT OF PRESCRIBERS

The plan covers the same coverage for a prescription written by a health care provider authorized to prescribe the particular drug, regardless of the type of health care provider that wrote the prescription. This section is intended to prohibit denial of coverage based on the prescription having been written by an advanced practice nurse, a physician assistant, or any other nonphysician provider authorized to prescribe the particular drug.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE

Cancer chemotherapy treatment cannot require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than what the health plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health plan company. A plan cannot achieve compliance by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent. A plan is in compliance if it does not include orally administered anticancer medication in the fourth or higher tier of its pharmacy benefit.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.308 HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES

The plan provides coverage for anesthesia and hospital charges for dental care provided to a covered person who is a child under age five, or is severely disabled, or has a medical condition and who requires hospitalization or general anesthesia for dental care treatment. The plan can require prior authorization of hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other conditions. The plan must provide coverage for general anesthesia and treatment rendered by a dentist for a medical condition covered by the health plan, regardless of whether the services are provided in a hospital or a dental office.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.3091 NONDISCRIMINATE COVERAGE OF TESTS

The plan provides the same coverage for laboratory tests, diagnostic tests, and x-rays , without requiring additional signatures, for all such tests ordered by an advanced practice nurse operating pursuant to Minnesota Statutes chapter 148.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.3093 COVERAGE FOR DIABETES

The plan provides coverage for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, and 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 includes persons with gestational, type I or type II diabetes. The cost of this coverage is no more than the cost sharing applicable to the plan's hospital, medical expense, medical equipment, or prescription drug benefits.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.3094 COVERAGE OF AUTISM SPECTRUM DISORDERS

The plan provides coverage for the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders, including (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. The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities. The coverage must include treatment that is in accordance with an individualized treatment plan prescribed by the enrollee's treating physician or mental health professional. The plan may request an updated treatment plan only once every six months, unless the plan and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances. 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. Definitions for autism spectrum disorders, medically necessary care, and "mental health professional" are provided in the statute.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) The plan meets the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.50 PROSTATE CANCER SCREENING

The plan covers 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. The screening consists at a minimum of a prostate-specific antigen blood test and a digital rectal examination.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.525 COVERAGE FOR OFF-LABEL DRUG USE

The drug coverage under the plan does not exclude coverage of a medically necessary formulary drug for the treatment of cancer on the ground that the drug has not been approved by the FDA 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. In this case, cost sharing must be no greater than that which typically would apply for the drug.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.526 COVERAGE FOR PARTICIPATION IN APPROVED CLINICAL TRIALS

The plan does not deny participation by a qualified individual in an approved clinical trial. The plan cannot 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. The plan does not discriminate against an individual on the basis of an individual's participation in an approved clinical trial. The plan can require a qualified individual to use an in-network provider, if that provider is participating in the trial and the provider accepts the individual as a participant in the trial. These requirements apply to in- and out-of-state clinical trials. See the statute for the definitions of "approved clinical trial," "qualified individual," and "routine patient costs."

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.527 NONFORMULARY ANTIPSYCHOTIC DRUGS

The plan provides prescription drug coverage for antipsychotic and other related drugs prescribed to treat emotional disturbance or mental illness regardless of whether the drug is on the formulary, if the prescribing provider indicates to the dispensing pharmacist that the prescription must be dispensed as communicated and the provider certifies in writing to the plan that all equivalent drugs on the formulary have been considered and has determined that the prescribed drug will best treat the patient's condition. The plan does not require the prescribing provider to recertify refills more often than the frequency of similar formulary drugs. The cost sharing must be equivalent to what it should be if the drug were on the formulary. The plan is not required to provide coverage for a drug removed from the formulary for safety reasons. Also, the plan must promptly grant an exception to the formulary for an enrollee when the prescribing provider indicates that the formulary drug causes an adverse reaction, or is contraindicated for the patient, or the provider demonstrates that the prescription drug must be dispensed as written in order to provide maximum medical benefit to the patient.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.53 MENTAL HEALTH COVERAGE; MEDICALLY NECESSARY CARE

With respect to the plan, "medically necessary care" means health care services appropriate, in terms of **type, frequency, level, setting, and duration**, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must help restore or maintain the enrollee's health or prevent deterioration of the condition.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.535 COVERAGE FOR COURT-ORDERED MENTAL HEALTH SERVICES

To the extent that the plan covers mental health services, the plan covers services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The plan must be given a copy of the court order and the behavioral care evaluation. The plan shall be financially liable for the evaluation if performed by a participating provider and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the plan and ordered to be provided by a participating provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by the plan under its utilization procedures. The plan may make a motion for modification of the court-ordered plan of care pursuant to the applicable rules of procedure for modification of the court's order. The motion may include a request for a new behavioral care evaluation.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.55 EMERGENCY SERVICES

The plan complies with the following: if emergency services are provided by a nonparticipating (out-of-network) provider, the plan cannot impose coverage restrictions or limitations that are more restrictive than that which apply to emergency services received from a participating (in-network) provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network. "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 (which is often referred to as the “EMTALA” standard). In other words, a hindsight review of whether a condition was actually an emergency or not is irrelevant; the prospective prudent layperson viewpoint must be used to derive the emergency services’ cost sharing treatment (this is also a federal requirement in effect since September 23, 2010, due to the Affordable Care Act). "Emergency services" means (1) a medical screening examination as under section 1867 of the Social Security Act that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, (2) within the

capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient (stabilize has the meaning given in section 1867(e)(3) of the Social Security Act), and (3) emergency services as defined in sections 245.462, subdivision 11, and 245.4871, subdivision 14, which includes coverage for emergency services outside of the hospital and emergency room setting, such as ambulances and crisis intervention personnel for mental health, substance use, suicide prevention, etc.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62Q.66 DURABLE MEDICAL EQUIPMENT COVERAGE

The plan does not use medical coverage criteria for durable medical equipment that limits coverage solely to equipment used in the home.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.672 COVERAGE OF TELEMEDICINE SERVICES

The plan includes coverage for medically necessary telemedicine benefits in the same manner as any other benefits covered under the plan. The plan may establish criteria that a 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. The plan can require the provider to agree to certain documentation or billing practices designed to protect against fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service. The plan does not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient. The plan reimburses providers on the same basis and at the same rate as the plan would apply to those services if the services had been delivered in person for the respective providers. Cost sharing does not exceed the cost sharing applicable if the same services were provided through in-person contact.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.042 FAMILY COVERAGE

The plan covers newborn infants immediately from the moment of birth and thereafter. The plan covers newborns for illness, injury, congenital malformation, or premature birth. The coverage includes inpatient or outpatient coverage for medical, dental, orthodontic and oral surgery incurred for the management of **cleft lip and cleft palate**. Newborn infants includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. The plan does not require notification as a condition for this coverage. However, the plan is entitled to all premiums that would have been collected had the plan been aware of the additional dependent.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES

The plan provides coverage for children health services and prenatal care without a deductible, copayment, or other coinsurance or dollar limitation requirement. Children health services means pediatric preventive services including immunizations, developmental assessments and laboratory services from birth to age six.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment __

☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.048 DEPENDENT COVERAGE

This provision must be followed if the plan covers children of employees. The plan allows dependent children who do not reside with the participant to be covered on the same basis as if they reside with the participant. The plan provides coverage to dependents covered by a qualified court or administrative order, and enrollment of a child cannot be denied on the basis that the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or the child does not reside with the parent or in the plan's service area.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.14 DISABLED CHILDREN

This provision must be followed if the plan covers children of employees. The plan cannot terminate the coverage of a child at age 26 (due to the Affordable Care Act) if the child is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (b) chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished by the employee within 31 days of the child's attainment of age 26 and beyond as may be required by the plan, but not more frequently than annually after the two-year period following the child's attainment of age 26. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this provision.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.141 COVERAGE FOR DISABLED DEPENDENTS

If the plan covers children of employees, the plan covers disabled dependents that is and continues to be both (1) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (2) chiefly dependent upon the employee for support and maintenance. The plan does not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning disabled dependents.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.148 GROUP INSURANCE; PROVISION OF BENEFITS FOR DISABLED EMPLOYEES.

An employer may not terminate, suspend or deny benefits payable under a policy to any covered employee due to absence caused by total disability. This includes coverage of the employee's dependents. The employee is responsible for no more than the premium charged prior to the total disability. During the first two years, total disability must be determined by the inability of an employee to perform the duties of the employee's own occupation. After the first two years, the total disability definition can be based on the inability of the employee to engage in any paid employment or work for which the employee may be reasonably qualified.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

62A.151 HEALTH BENEFITS FOR EMOTIONALLY DISABLED CHILDREN

If the plan covers children of employees, the plan provides health service benefits for the treatment of emotionally disabled children in a residential treatment facility licensed by the commissioner of human services on the same basis as inpatient hospital. "Emotionally disabled child" has the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.27 COVERAGE OF ADOPTED CHILDREN

If the plan covers children of employees, the plan must cover adopted children on the same basis as other dependents effective from the date of placement for adoption. The plan does not require notification as a condition for this coverage. However, the plan may collect all premiums that would have been collected had the plan been aware of the additional dependent.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.

62A.302 COVERAGE OF DEPENDENTS

This provision must be followed if the plan covers children of employees. The plan must define "dependent" no more restrictively than the definition provided in section 62L.02, subdivision 11. With respect to a child who has not attained age 26, the plan shall not define child dependent in any other terms other than a relationship between a child and the employee or spouse of the employee. The plan does not deny or restrict coverage for a child who has not attained 26 years of age based on financial dependency on the employee, residence with the employee or with any other person, marital status, student status, employment status, or any combination of these factors. The plan cannot deny or restrict coverage of a child based on eligibility for other coverage, except if the child is age 26 or older. The plan may exclude coverage for a grandchild, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild or the grandchild meets the requirements of section 62A.042.

NOTE: In terms of allowing employees and separately, their dependents, to terminate from a plan at the timing they desire, many political subdivisions have relied on ERISA's life event rules. ERISA does not apply to government plans. In addition, many plans are also referencing Section 125 cafeteria plan provisions, however, these provisions are not a part of their benefit plan structure. All political subdivision plans are subject to applicable state laws, even if they are self-insured. The Commerce Department would view the facts and circumstances of cases where an enrollee wishes to disenroll and cannot due to a plan's rules in light of state laws, including the section 62A.02, subdivision 3, which requires that premiums are reasonable in relation to benefits provided.

☐ Attested ☐ Not Compliant, the deviation and remediation plan is provided on Attachment ___

☐ Not applicable, as the plan does not cover any employees' child dependents.