4685.0700 COMPREHENSIVE HEALTH MAINTENANCE SERVICES.

Subpart 1. **Providing health maintenance services.** All health maintenance organizations shall provide comprehensive health maintenance services, as defined in part 4685.0100, subpart 5, to enrollees.

Subp. 2. **Minimum services.** Such comprehensive health maintenance services shall include but need not be limited to:

A. provisions for emergency in area health care services which shall be available 24 hours a day, seven days a week; be provided either directly through health maintenance organization facilities or through arrangements with other providers; be provided by a physician and other licensed and ancillary health personnel, as appropriate, readily available at all times; and be covered for enrollees requiring such services but who, for reasons of medical necessity and not convenience, are unable to obtain them directly from the health maintenance organization in which they are enrolled or from providers or other persons with whom the health maintenance organization in which they are enrolled has arrangements for the provision of services;

B. provisions covering out-of-area services which must include out-of-area emergency care;

C. all inpatient hospital care, including mental health and chemical dependency care, except as exclusions or limitations are hereafter permitted;

D. all inpatient physician care except as exclusions or limitations are hereafter permitted;

E. all outpatient health services, including mental health and chemical dependency services, except as exclusions or limitations are hereafter permitted; and

F. procedures for providing preventive health services.

Subp. 3. **Permissible limitations.** A health service that may be excluded under subpart 4 may instead be limited. The following health services may be limited, but cannot be excluded:

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 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.

(b) When a health maintenance organization grants an exception to the formulary, it may charge the enrollee the approved flat fee copayment or a copayment that does not exceed 25 percent of the provider's charge, in accordance with part 4685.0801.

B. A health maintenance organization may limit durable medical equipment, orthotics, prosthetics, and nondurable medical supplies.

C. A health maintenance organization may limit home health care services.

D. A health maintenance organization may limit inpatient hospital care as defined in part 4685.0100, subpart 5, item B, and required in subpart 2, item C, as specifically authorized by this item. Each health maintenance organization may have limitations upon the number of days of inpatient hospital care that at least correspond with the following minimum provisions:

(1) 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.

(2) 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.

(3) 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, but which may be limited, as indicated. These provisions do not relate to custodial care that may be limited or excluded completely pursuant to subpart 4, item H, nor do these provisions allow limitations relative to the spectrum of service during a covered day, which is provided for in subpart 4.

Subp. 4. **Permissible exclusions.** The following services may be excluded:

A. personal convenience devices;

B. cosmetic services, except for reconstructive surgery as required under Minnesota Statutes, section 62A.25;

C. dental services;

D. nonemergency ambulance services and special transportation services, except as provided by Minnesota Statutes, section 62J.48;

E. the fitting and provision of contact lenses, eyeglasses, and hearing aids;

F. 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;

(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;

G. custodial care;

H. care for injuries incurred while on military duty, to the extent that care for the injuries is covered or available in another program of coverage;

I. services and other items not prescribed, recommended, or approved by a provider who is providing services through the enrollee's health maintenance organization or a provider to whom the enrollee is referred;

J. the following services relating to inpatient hospitalization:

(1) television, telephone, and similar convenience or amenity items that are available in connection with inpatient hospital care but that are not medically necessary as a part of the enrollee's care;

(2) hospital private room accommodations unless medically necessary; and

(3) inpatient hospital care under any circumstances where inpatient physician care or the procedure is not otherwise covered; and

K. services for those conditions subject to underwriting restrictions when the imposition of the restrictions is otherwise proper, provided that underwriting restrictions may only relate to preexisting health conditions, and those acute health conditions for which an applicant is being treated at the time of the proposed enrollment.

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