Subd. 5. **MAINTENANCE RESPONSIBILITIES.** For all occupancies covered by this section where the occupant is not the owner of the dwelling unit or the guest room, the owner is responsible for maintenance of the smoke detectors. An owner may file inspection and maintenance reports with the local fire marshal for establishing evidence of inspection and maintenance of smoke detectors.

Sec. 5. Minnesota Statutes 1986, section 299F.362, is amended by adding a subdivision to read:

Subd. 5a. **INFORM OWNER; NO ADDED LIABILITY.** The occupant of a dwelling unit must inform the owner of the dwelling unit of a nonfunctioning smoke detector within 24 hours of discovering that the smoke detector in the dwelling unit is not functioning. If the occupant fails to inform the owner under this subdivision, the occupant's liability for damages is not greater than it otherwise would be.

Sec. 6. Minnesota Statutes 1986, section 299F.362, subdivision 6, is amended to read:

Subd. 6. ~~**PENALTY**~~ **PENALTIES.** (a) Any person who violates any provision of this section shall be subject to the same penalty incurred for violation of the uniform fire code, as specified in section 299F.011, subdivision 6.

(b) An occupant who willfully disables a smoke detector or causes it to be nonfunctioning, resulting in damage or injury to persons or property, is guilty of a misdemeanor.

Approved May 21, 1987

CHAPTER 202—S.F.No. 292

An act relating to insurance; health and accident; requiring coverage for scalp hair prostheses in certain circumstances; amending Minnesota Statutes 1986, section 62E.06, subdivision 1; and proposing coding for new law in Minnesota Statutes, chapter 62A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62A.28] COVERAGE FOR SCALP HAIR PROSTHESES.**

Subdivision 1. **SCOPE OF COVERAGE.** This section applies to all policies of accident and health insurance, health maintenance contracts regulated under chapter 62D, health benefit certificates offered through a fraternal beneficiary association regulated under chapter 64B, and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C. This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis, or policies that provide only accident coverage.

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 a policy's copayment requirement and is limited to a maximum of $350 in any benefit year, exclusive of any deductible.

Sec. 2. Minnesota Statutes 1986, section 62E.06, subdivision 1, is amended to read:

Subdivision 1. **NUMBER THREE PLAN.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A and 62C, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall be subject to a maximum lifetime benefit of not less than $250,000.

The $3,000 limitation on total annual out-of-pocket expenses and the $250,000 maximum lifetime benefit shall not be subject to change or substitution by use of an actuarially equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) hospital services;

(2) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at the physician's direction;

(3) drugs requiring a physician's prescription;

(4) services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under medicare;

(5) services of a home health agency if the services would qualify as reimbursable services under medicare;

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

(9) prostheses other than dental but including scalp hair prostheses worn for hair loss suffered as a result of alopecia areata;

(10) rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

(11) diagnostic X-rays and laboratory tests;

(12) oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) services of a physical therapist; and

(14) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, medicare or any other governmental program except as otherwise provided by law;

(2) any charge for treatment for cosmetic purposes other than 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;

(3) care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare;

(4) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semiprivate rooms, its most common semiprivate room charge shall be considered to be 90 percent of its lowest private room charge;

(5) that part of any charge for services or articles rendered or prescribed by

a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

(f) Effective August 1, 1985, the minimum benefits of a qualified plan must include, in addition to the benefits specified in clauses (a), (d), and (e), coverage for special dietary treatment for phenylketonuria when recommended by a physician.

Approved May 21, 1987

CHAPTER 203—S.F.No. 577

An act relating to business corporations; regulating mergers and exchanges; amending Minnesota Statutes 1986, sections 302A.111, subdivision 2; 302A.471, subdivisions 1 and 3; 302A.601, subdivision 2; 302A.611; 302A.613; 302A.615; 302A.631; and 302A.641, subdivision 1.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1986, section 302A.111, subdivision 2, is amended to read:

Subd. 2. **STATUTORY PROVISIONS THAT MAY BE MODIFIED ONLY IN ARTICLES.** The following provisions govern a corporation unless modified in the articles:

(a) A corporation has general business purposes (section 302A.101);

(b) A corporation has perpetual existence and certain powers (section 302A.161);

(c) The power to adopt, amend, or repeal the bylaws is vested in the board (section 302A.181);