62A.25 RECONSTRUCTIVE SURGERY.

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 benefit society regulated under chapter 64B, and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C but 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.** (a) 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 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. Coverage may not:

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.

History: *1980 c 496 s 1; 1985 c 49 s 41; 1992 c 564 art 1 s 54; 2002 c 330 s 10*