

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Sec. 1357.001. DEFINITIONS. In this subchapter:

(1) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy has been performed and surgical reconstruction of a breast on which mastectomy has not been performed.

(2) "Enrollee" means an individual entitled to coverage under a health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

- (1) an insurance company;
- (2) a group hospital service corporation operating under Chapter 842;
- (3) a fraternal benefit society operating under Chapter 885;
- (4) a stipulated premium company operating under Chapter 884;
- (5) a reciprocal exchange operating under Chapter 942;
- (6) a health maintenance organization operating under Chapter 843;
- (7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter [844](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.003. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit, other than benefits for cancer;

(B) only for accidental death or dismemberment;

(C) only for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) only for credit insurance;

(E) only for dental or vision care;

(F) only for indemnity for hospital confinement;

or

(G) as a supplement to a liability insurance policy;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section [1357.002](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

(b) Coverage required under this section:

(1) shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee;

(2) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and

(3) may not be subject to dollar limits other than the lifetime maximum benefits under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.005. PROHIBITED CONDUCT. (a) An issuer of a health benefit plan may not:

(1) offer a financial incentive for an enrollee to not receive breast reconstruction or to waive the coverage required under this subchapter;

(2) condition, limit, or deny the eligibility of a person to enroll in the plan or to renew coverage under the terms of the plan solely to avoid the requirements of this subchapter; or

(3) reduce or limit the reimbursement or amount paid to, or otherwise penalize, an attending physician or provider or provide a financial incentive or other benefit to an attending physician or provider to induce the physician or provider to provide care to an enrollee in a manner that is inconsistent with this subchapter.

(b) This section does not prevent an issuer of a health benefit plan from negotiating with a physician or provider the level and type of reimbursement that the physician or provider will receive for care provided in accordance with this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.006. NOTICE OF COVERAGE. (a) An issuer of a

health benefit plan that provides coverage under this subchapter shall provide to each enrollee notice of the availability of the coverage.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.007. RULES. The commissioner may adopt rules to implement this subchapter and to meet the minimum requirements of federal law.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

#### SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND CERTAIN RELATED PROCEDURES

Sec. 1357.051. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

- (i) an insurance company;
- (ii) a group hospital service corporation operating under Chapter [842](#);
- (iii) a fraternal benefit society operating under Chapter [885](#);
- (iv) a stipulated premium company operating under Chapter [884](#); or
- (v) a health maintenance organization

operating under Chapter [843](#); and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter [844](#); or

(3) provides coverage only for a specific disease or condition or for hospitalization.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for accidental death or dismemberment;

(B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(C) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter [1501](#);

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section [1357.052](#).

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of breast cancer must provide to each enrollee coverage for inpatient care for a minimum of:

- (1) 48 hours following a mastectomy; and
- (2) 24 hours following a lymph node dissection for the treatment of breast cancer.

(b) A health benefit plan is not required to provide the minimum hours of coverage of inpatient care required under Subsection (a) if the enrollee and the enrollee's attending physician determine that a shorter period of inpatient care is appropriate.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.055. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(1) deny the eligibility or continued eligibility of an individual to enroll in the plan or renew coverage under the plan solely to avoid the requirements of this subchapter;

(2) provide money payments or rebates to an enrollee to encourage the enrollee to accept less than the minimum coverage required under this subchapter;

(3) reduce or limit the amount paid to an attending physician, or otherwise penalize the physician, because the physician provided care to an enrollee in accordance with this subchapter; or

(4) provide financial or other incentives to an attending physician to encourage the physician to provide care to an enrollee in a manner inconsistent with this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.056. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each enrollee written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1357.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.