

HB453 INTRODUCED



1 HB453
2 NRX4B8J-1
3 By Representatives Fidler, Givens, Drummond, Hollis, Tillman,
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5 Moore (M), Hulsey, Myrex, Paschal, Wilcox, Lamb, Morris,
6 Givan, Nelson, Treadaway, Pettus, Gray, Sellers, Easterbrook,
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10 Bolton, Mooney, Warren, Yarbrough, Starnes, Reynolds
11 RFD: Insurance
12 First Read: 12-Feb-26



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4 SYNOPSIS:

5 This bill would require that breast
6 reconstruction be provided under all health insurance
7 plans in the State of Alabama, including those covering
8 public employees and the Medicaid program.

9 This bill would permit an insured individual to
10 choose the type of breast reconstruction desired and a
11 particular surgeon to perform the reconstruction, who
12 may be outside of the health insurance benefit plan
13 network.

14 For private health insurance, this bill would
15 also set terms for cost-sharing obligations for
16 enrollees and insurer payments to out-of-network
17 providers.

18 This bill would provide that an insured
19 individual or a health care professional may bring a
20 civil action if the insurer fails to comply with this
21 act, with enforcement powers given to the Attorney
22 General and the Commissioner of the Department of
23 Insurance.

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 A BILL
 TO BE ENTITLED
 AN ACT



30 Relating to health insurance; to add Chapter 50A,
31 commencing with Section 27-50A-1, to Title 27, Code of Alabama
32 1975, to require health benefit plans to cover breast
33 reconstruction; to define the scope of breast reconstruction
34 benefits and provide requirements for payments to health care
35 providers; to amend Section 10A-20-6.16, Code of Alabama 1975,
36 to make conforming changes; to amend Section 27-21A-23, Code
37 of Alabama 1975, to make conforming changes; to amend Section
38 16-25A-6, Code of Alabama 1975, to make conforming changes; to
39 add Section 16-25A-6.1 to the Code of Alabama 1975, to require
40 the Public Education Employees' Health Insurance Plan to cover
41 breast reconstruction; to add Section 22-6-11.1 to the Code of
42 Alabama 1975, to require Medicaid coverage for breast
43 reconstruction; to add Section 36-29-4.1 to the Code of
44 Alabama 1975, to require the State Employees' Health Insurance
45 Plan to cover breast reconstruction; and to amend Section
46 36-29-5, Code of Alabama 1975, to make conforming changes

47 BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

48 Section 1. Chapter 50A, commencing with Section
49 27-50A-1, is added to Title 27 of the Code of Alabama 1975, to
50 read as follows:

51 §27-50A-1

52 The Legislature finds:

53 (1) Breast cancer affects thousands of Alabama women
54 annually and access to comprehensive reconstruction surgery is
55 essential to physical and psychological recovery.

56 (2) No woman residing in the State of Alabama should be



57 denied access to appropriate breast reconstruction surgery due
58 to network limitations or excessive administrative
59 requirements.

60 (3) The State of Alabama has a compelling public health
61 interest in fostering as broad an access as possible to breast
62 reconstruction services and by this act seeks to ensure
63 flexibility and patient choice in accessing breast
64 reconstruction care that is both appropriate for the
65 individual and comprehensive.

66 §27-50A-2

67 For the purposes of this chapter, the following terms
68 have the following meanings:

69 (1) BREAST RECONSTRUCTION. The medical repair of
70 physical defects caused by the removal or treatment of breast
71 tissue as a result of trauma, disease, lumpectomy, mastectomy,
72 or prophylaxis against future disease, which has as its
73 purpose the reconstruction of a new breast mound or a flat
74 chest wall and the establishment of symmetry between two
75 breasts, and which includes:

76 a. Augmentation or reduction;

77 b. All stages of preparatory, primary, and revision
78 surgery to reconstruct a breast mound or to create a new
79 breast mound;

80 c. All necessary procedures for a non-diseased,
81 contralateral breast to create symmetry between two breasts;

82 d. Chest wall reconstruction, including, but not
83 limited to, a flat closure that uses adjacent tissue transfer
84 or complex repair to eliminate all redundancies of skin and



85 soft tissue;

86 e. Custom-fabricated breast prostheses, including, but
87 not limited to, replacement of the breast prostheses;

88 f. Hybrid procedures that involve both autologous
89 breast reconstruction and biologic or synthetic products or
90 devices; and

91 g. Mechanical, medical, or surgical prophylaxis to
92 prevent the physical complications of a mastectomy, breast
93 conserving surgery, chest wall reconstruction, radiation, or
94 lymph node surgery.

95 h. Mechanical, medical, and surgical treatment of
96 physical complications of a mastectomy, breast conserving
97 surgery, chest wall reconstruction, radiation, or lymph node
98 surgery.

99 (2) COMMISSIONER. The Commissioner of the Department of
100 Insurance of the State of Alabama.

101 (3) CORE-BASED STATISTICAL AREA. A metropolitan or
102 micropolitan statistical area as defined by the U.S. Office of
103 Management and Budget.

104 (4) COST-SHARING. An enrollee's payment obligation for
105 a covered health care service, including a deductible,
106 copayment, or coinsurance.

107 (5) ENROLLEE. A patient who is covered under a health
108 benefit plan.

109 (6) HEALTH BENEFIT PLAN. Any individual or group plan,
110 employee welfare benefit plan, policy, or contract for health
111 care services issued, delivered, issued for delivery, or
112 renewed in this state by a health care insurer, health



113 maintenance organization, accident and sickness insurer,
114 fraternal benefit society, nonprofit hospital service
115 corporation, nonprofit medical service corporation, health
116 care service plan, or any other person, firm, corporation,
117 joint venture, or other similar business entity that pays for
118 insureds or beneficiaries in this state. The term includes,
119 but is not limited to, entities created pursuant to Article 6
120 of Chapter 20 of Title 10A. A health benefit plan located or
121 domiciled outside of the State of Alabama is deemed to be
122 subject to this chapter if it receives, processes,
123 adjudicates, pays, or denies claims for health care services
124 submitted by or on behalf of patients, insureds, or
125 beneficiaries who reside in Alabama. The term shall not
126 include accident-only, specified disease, hospital indemnity,
127 Medicare supplement, long-term care, disability income, or
128 other limited benefit health insurance policies.

129 (7) HEALTH CARE PROFESSIONAL. A physician, physician
130 assistant, or certified registered nurse practitioner licensed
131 pursuant to Title 34, including, but not limited to, a
132 physician who performs plastic and reconstructive surgery or
133 who is a referring or consulting physician providing oncology
134 treatment or breast surgery, or an employee acting under the
135 direction of the same.

136 (8) HEALTH CARE SERVICES. The term includes, but is not
137 limited to, all of the following:

138 a. Health care professional services, including, but
139 not limited to, consultation, diagnosis, treatment,
140 anesthesia, surgery, and therapy.



141 b. Prescription drugs.
142 c. Facilities, including a hospital or ambulatory
143 surgical treatment center.

144 d. Prostheses and devices for breast reconstruction,
145 including tissue expanders, customized implants, and nerve
146 graft products, mesh, or repair products.

147 (9) INSURER. The term includes all of the following:

148 a. Any entity that issues, delivers, or renews a health
149 benefit plan.

150 b. Any department or office of the entity described in
151 paragraph a., or any individual employed by the entity, which
152 performs utilization review or makes determinations of prior
153 authorization or coverage.

154 c. Any separate entity or individual that is a
155 contractor or agent of the entity described in paragraph a.
156 which performs utilization review or makes determinations of
157 prior authorization or coverage.

158 (10) MODALITY, TYPE, AND TECHNIQUE. A method of breast
159 reconstruction surgery that employs a modality such as an
160 implant, natural tissue, or fat, or some combination of the
161 foregoing, and includes any of the following types and
162 techniques:

163 a. Immediate implant-based, tissue-based, or combined
164 reconstruction.

165 b. Delayed implant-based, tissue-based, or combined
166 reconstruction.

167 c. Myocutaneous flap tissue-based reconstruction.

168 d. Microvascular free flap tissue-based reconstruction.



169 e. Structural fat grafting tissue-based breast
170 reconstruction.

171 f. Combined implant-based and tissue-based breast
172 reconstruction.

173 g. Any type of breast reconstruction that is developed
174 subsequent to the effective date of this act that is
175 recognized within Level I or Level II of the Healthcare Common
176 Procedure Coding System (HCPCS) codes.

177 h. All techniques and procedural variations,
178 iterations, or approaches associated with a type of breast
179 reconstruction, as noted within the short descriptor or
180 description for the Level I Healthcare Common Procedure Coding
181 System code covering the type of breast reconstruction.

182 (11) NETWORK PROVIDER. A health care professional or
183 facility that participates in the provider network of a
184 health benefit plan to receive a contractually-established
185 amount as payment in full for providing health care services.

186 (12) OUT-OF-NETWORK PROVIDER. A health care
187 professional or facility located anywhere in the United States
188 which does not receive a contractually-established amount from
189 an insurer or health benefit plan as payment in full for
190 providing health care services.

191 (13) PREVAILING MEDICAL STANDARD. The standards of care
192 for breast reconstruction established by national specialty
193 organizations, including the American Society of Plastic
194 Surgeons, the American Society for Reconstructive
195 Microsurgery, the American Society of Breast Surgeons, the
196 National Comprehensive Cancer Network, and other

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197 nationally-recognized medical specialty organizations, the
198 members of which routinely perform breast reconstruction
199 surgery.

200 \$27-50A-3

201 (a) On and after January 1, 2027, a health benefit plan
202 shall pay or reimburse for breast reconstruction, including
203 all component health care services, subject to the
204 requirements of this chapter.

205 (b) Coverage for breast reconstruction shall include
206 any modality, type, and technique chosen by an enrollee in
207 consultation with her health care professional based on
208 personal factors such as the enrollee's anatomy, health
209 status, preference, lifestyle, and reconstruction goals.

210 (c) Coverage shall include health care services for the
211 breast reconstruction which are rendered by either a network
212 or out-of-network provider as selected by an enrollee,
213 provided that any surgeon shall be board certified or eligible
214 for board certification in plastic and reconstructive surgery.

215 (d) The modality, type, and technique of breast
216 reconstruction chosen by an enrollee in consultation with her
217 surgeon who meets the requirement of subsection (c) shall be
218 presumed by the insurer to meet both: (i) prevailing medical
219 standards; and (ii) the requirement of medical necessity for
220 purposes of a request for prior authorization.

221 (e) Coverage for breast reconstruction shall extend to
222 all health care services that are necessary to achieve the
223 breast reconstruction outcome determined appropriate by the
224 the enrollee and her health care professional, including the



225 initial and all subsequent surgeries required by the modality,
226 type, and technique and not limited with respect to any
227 revision surgery, symmetry procedure, nipple reconstruction,
228 lymphovenous bypass, tattooing, nerve grafting, scar revision,
229 fat grafting, or treatment for a complication.

230 \$27-50A-4

231 (a) An insurer shall respond to a request for prior
232 authorization for breast reconstruction no later than three
233 business days after the date and time of the submission of the
234 request.

235 (b) (1) An insurer may deny a request for prior
236 authorization of a specific modality, type, and technique of
237 breast reconstruction chosen by an enrollee in consultation
238 with her health care professional if the conditions in this
239 subsection are met.

240 (2) Any determination of denial shall be made upon
241 review of the request and all relevant clinical information by
242 a health care professional who: (i) is board certified or
243 eligible for board certification in plastic surgery and
244 reconstructive surgery; and (ii) has specific training in the
245 modality, type, and technique at issue.

246 (3) The reviewing health care professional shall rebut
247 the presumption of medical necessity recognized under Section
248 27-50A-3(d) by providing to the enrollee and her health care
249 professional articulable reasons in writing that support a
250 conclusion that: (i) the modality, type, and technique
251 proposed fails to comport with prevailing medical standards;
252 or (ii) clinical considerations unique to the enrollee make



253 the enrollee a poor candidate for the modality, type, and
254 technique requested.

255 (4) An enrollee or health care professional whose
256 request for prior authorization is denied may appeal the
257 denial in the internal appeal process afforded by the insurer,
258 provided the appeal is determined by a health care
259 professional who did not perform the initial review but who
260 otherwise meets the requirements of subdivision (2).

261 (5) A health care professional acting on behalf of an
262 insurer, who meets the requirements of subdivision (2), while
263 a denial of prior authorization is under consideration, or
264 pursuant to an appeal of a denial of prior authorization under
265 subdivision (4), shall provide a direct telephone number to
266 the enrollee's health care professional, and may request or
267 shall consider additional clinical information concerning the
268 enrollee for purposes of review.

269 (c) An insurer may not deny a request for prior
270 authorization of the modality, type, and technique of breast
271 reconstruction chosen by the enrollee in consultation with her
272 health care professional on any of the following grounds:

273 (1) A different modality, type, and technique of breast
274 reconstruction is also appropriate for the enrollee, in
275 absence of articulable reasons required under subdivision
276 (b) (3).

277 (2) The health care services required in providing
278 coverage, including the plastic surgeon or facility, are
279 out-of-network, unless the individual or facility proposed to
280 render the health care service is outside of the United States



281 or does not hold the necessary professional or other license
282 under the law of the state where the individual or facility is
283 located.

284 (3) The modality, type, and technique of breast
285 reconstruction requested by the enrollee or her health care
286 professional is more expensive than the modality, type, and
287 technique or the related health care services proposed by the
288 insurer.

289 §27-50A-5

290 (a) An enrollee's cost-sharing obligations for breast
291 reconstruction shall not exceed the health benefit plan's
292 rates that apply to network providers for comparable coverages
293 under the plan, and an enrollee who receives health care
294 services for breast reconstruction from health care
295 professionals, facilities, or other services that are
296 out-of-network shall pay in-network cost-sharing rates.

297 (b) Other coverages provided under the health benefit
298 plan may not be limited or reduced as a result of including in
299 the plan the coverage described in this chapter.

300 (c) If an enrollee receives coverage for breast
301 reconstruction, the enrollee's contractual right to other
302 coverages or benefits available under the health benefit plan
303 may not in any way be reduced or limited, nor may receiving
304 coverage for breast reconstruction render an enrollee
305 ineligible to renew coverage under the plan.

306 (d) The requirements of this chapter apply regardless
307 of whether the health benefit plan otherwise provides coverage
308 for out-of-network services or contains any provision that



309 purports to limit or exclude out-of-network coverage.

310 \$27-50A-6

311 (a) (1) A health benefit plan may not impose a
312 requirement that an enrollee receive breast reconstruction
313 health care services from a network provider as a condition
314 for coverage.

315 (2) An insurer shall approve the choice of an enrollee
316 to receive health care services from a health care
317 professional who is an out-of-network provider, unless the
318 individual proposed to render the service does not hold the
319 necessary professional license under the law of the state
320 where the entity or individual is located.

321 (3) The requirement of subdivision (2) applies to an
322 out-of-network hospital or facility in which surgery is to be
323 performed if the hospital or facility complies with the
324 applicable licensure or certification requirements under
325 federal law and the law of the state where the hospital or
326 facility is located.

327 (b) With respect to a surgeon who is an out-of-network
328 provider chosen by an enrollee, an insurer may not do any of
329 the following:

330 (1) Undertake any communication or action, or impose
331 any provision, that has the effect of discouraging the
332 enrollee from choosing the surgeon, including any incentive,
333 disincentive, or penalty related to the enrollee's health
334 benefit plan coverage.

335 (2) Require the enrollee to first consult with or
336 consider a surgeon who is a network provider.



337 (3) Undertake any communication or action, or impose
338 any provision, that has the effect of steering the enrollee to
339 choose a surgeon who is a network provider, including any
340 incentive, disincentive, or penalty related to the enrollee's
341 health benefit plan coverage.

342 (4) Impose additional administrative, licensure,
343 certification, or qualification requirements, including
344 documentation, in excess of what is required for
345 out-of-network providers for other coverages under the health
346 benefit plan.

347 (c) An insurer may not use any indirect means to
348 prevent, disincentivize, or discourage an enrollee from
349 receiving a health care service from an out-of-network
350 provider, including influencing, inducing, or pressuring a
351 hospital or other facility to require a surgeon to be a
352 network provider of the insurer as a condition for obtaining
353 or maintaining medical staff privileges to perform breast
354 reconstruction.

355 §27-50A-7

356 An insurer may not withdraw an approval of prior
357 authorization for breast reconstruction communicated to a
358 health care professional or enrollee, nor may an insurer
359 refuse or fail to reimburse a health care professional for a
360 health care service after it has communicated the approval of
361 prior authorization, unless an enrollee or health care
362 provider made a misrepresentation by statement or omission to
363 the insurer which was material to the approval of prior
364 authorization.



365 §27-50A-8

366 (a) If a health care service included in breast
367 reconstruction is rendered by an out-of-network provider, this
368 section shall govern the rate of reimbursement.

369 (b) If an enrollee selects an out-of-network provider,
370 the insurer shall initiate single case agreement negotiations
371 with the provider according to all of the following
372 conditions:

373 (1) The insurer shall initiate negotiations with the
374 provider within five business days of receiving notice of the
375 enrollee's selection.

376 (2) The insurer and the provider shall have 10 business
377 days from initiation of negotiations to agree on reimbursement
378 terms.

379 (3) If the insurer and provider reach agreement, the
380 agreed terms shall govern reimbursement for the health care
381 services covered by the single case agreement.

382 (4) If the insurer fails to initiate negotiations
383 within the time required, fails to negotiate in good faith, or
384 the insurer and provider do not reach agreement within 10
385 business days, the payment provisions of subsection (c) shall
386 govern the rate of reimbursement.

387 (5) An insurer's failure to respond to a provider's
388 communication within two business days during the negotiating
389 period shall be deemed a failure to negotiate in good faith.

390 (c) If the conditions provided in subsection (b) are
391 not met, the health benefit plan shall reimburse the provider
392 an amount that is the lesser of:



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393 (1) The provider's billed charges; or
394 (2) The 80th percentile of all charges for the same
395 provider service in the same core-based statistical area in
396 which the provider service is performed, as reported in a
397 database that is maintained by a nonprofit organization that
398 is unaffiliated or not otherwise financially supported by any
399 insurer.

400 (d) If the health benefit plan fails to reimburse an
401 out-of-network provider as required under subsection (a), in
402 addition to making the required payment, the health benefit
403 plan shall pay the out-of-network provider an amount that is
404 treble the difference between:

405 (1) The initial reimbursement, or in the case of denial
406 of payment, zero dollars (\$0); and
407 (2) The reimbursement rate required under subsection
408 (c) less any cost-sharing amount to be paid by the insured.

409 (e) The payment required under subsection (d) shall be
410 subject to interest at a rate to be specified by rule adopted
411 by the department.

412 §27-50A-9

413 If an enrollee who has received prior authorization for
414 breast reconstruction subsequently enrolls in a different
415 health benefit plan offered by the same insurer, or in a
416 health benefit plan offered by a different insurer, any health
417 care service necessary to achieve the breast reconstruction
418 outcome determined appropriate by the enrollee and her health
419 care professional, including any health care service for
420 revision or to treat a complication, shall be covered.



421 \$27-50A-10

422 (a) An enrollee or health care professional who is
423 injured as a result of an insurer's failure to comply with
424 this chapter may bring a civil action against the insurer in
425 the Circuit Court of Montgomery County or in the circuit court
426 of the county where the enrollee resides.

427 (b) In an action brought under this section, the court
428 may award to the plaintiff any of the following:

429 (1) Injunctive relief.

430 (2) Compensatory damages.

431 (3) Treble damages upon a finding that failure of an
432 insurer to comply with this chapter was knowing or in reckless
433 disregard of the provisions of this chapter.

434 (4) Reasonable costs and attorney fees.

435 (c) An action brought under this section may be
436 predicated upon any common law or statutory cause of action,
437 including breach of contract or any applicable tort, including
438 fraud or bad faith, or a deceptive trade practice under
439 Chapter 19 of Title 8.

440 \$27-50A-11

441 The commissioner and the Attorney General have
442 concurrent jurisdiction to enforce this chapter, to include
443 any of the following measures:

444 (1) The commissioner may investigate complaints or
445 conduct compliance audits pursuant to Article 1 of Chapter 2.

446 (2) The Attorney General may investigate complaints
447 pursuant to Section 8-19-9 and cooperate with the department
448 in conducting investigations.



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449 (3) The commissioner or the Attorney General may bring
450 a civil action against an insurer in the Circuit Court of
451 Montgomery County for injunctive relief to enforce compliance
452 with this chapter, or in a representative capacity on behalf
453 of aggrieved enrollees to include recovery of compensatory
454 damages.

455 (4) The commissioner or the Attorney General may
456 intervene as a plaintiff in any private action brought under
457 Section 27-50A-10 if the issues raised are broad or
458 significant enough in application to be in the public
459 interest.

460 §27-50A-12

461 (a) An insurer shall provide a written notice to an
462 enrollee which contains a summary of the enrollee's rights
463 under this chapter when any of the following occurs:

464 (1) Upon initial enrollment in a health benefit plan.

465 (2) Upon annual renewal of a health benefit plan.

466 (3) Within five business days of the insurer receiving
467 notice that an enrollee has been diagnosed with breast cancer
468 or has undergone a mastectomy or lumpectomy.

469 (b) (1) The notice required under subsection (a) shall
470 include, at a minimum, a plain-language summary of the
471 enrollee's right: (i) to choose any qualified plastic surgeon
472 for breast reconstruction; (ii) to receive coverage for health
473 care services from out-of-network providers at in-network
474 cost-sharing rates; and (iii) to appeal any denial of
475 coverage.

476 (2) The commissioner shall develop a model notice for

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477 use by an insurer to comply with this section.

478 \$27-50A-13

479 The commissioner shall adopt rules to implement and
480 administer this chapter.

481 Section 2. Sections 10A-20-6.16 and 27-21A-23, Code of
482 Alabama 1975, are amended to read as follows:

483 "§10A-20-6.16

484 (a) No statute of this state applying to insurance
485 companies shall be applicable to any corporation organized
486 under this article and amendments thereto or to any contract
487 made by the corporation; except the corporation shall be
488 subject to the following:

489 (1) The provisions regarding annual premium tax to be
490 paid by insurers on insurance premiums.

491 (2) Chapter 55 of Title 27.

492 (3) Article 2 and Article 3 of Chapter 19 of Title 27.

493 (4) Section 27-1-17.

494 (5) Chapter 56 of Title 27.

495 (6) Rules adopted by the Commissioner of Insurance
496 pursuant to Sections 27-7-43 and 27-7-44.

497 (7) Chapter 54 of Title 27.

498 (8) Chapter 57 of Title 27.

499 (9) Chapter 58 of Title 27.

500 (10) Chapter 59 of Title 27.

501 (11) Chapter 54A of Title 27.

502 (12) Chapter 12A of Title 27.

503 (13) Chapter 2B of Title 27.

504 (14) Chapter 29 of Title 27.



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505 (15) Chapter 62 of Title 27.

506 (16) Chapter 63 of Title 27.

507 (17) Chapter 45A of Title 27.

508 (18) Chapter 50A of Title 27.

509 (b) The provisions in subsection (a) that require
510 specific types of coverage to be offered or provided shall not
511 apply when the corporation is administering a self-funded
512 benefit plan or similar plan, fund, or program that it does
513 not insure."

514 "§27-21A-23

515 (a) Except as otherwise provided in this chapter,
516 provisions of the insurance law and provisions of health care
517 service plan laws shall not be applicable to any health
518 maintenance organization granted a certificate of authority
519 under this chapter. This provision shall not apply to an
520 insurer or health care service plan licensed and regulated
521 pursuant to the insurance law or the health care service plan
522 laws of this state except with respect to its health
523 maintenance organization activities authorized and regulated
524 pursuant to this chapter.

525 (b) Solicitation of enrollees by a health maintenance
526 organization granted a certificate of authority shall not be
527 construed to violate any provision of law relating to
528 solicitation or advertising by health professionals.

529 (c) Any health maintenance organization authorized
530 under this chapter shall not be deemed to be practicing
531 medicine and shall be exempt from the provisions of Section
532 34-24-310, et seq., relating to the practice of medicine.



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533 (d) No person participating in the arrangements of a
534 health maintenance organization other than the actual provider
535 of health care services or supplies directly to enrollees and
536 their families shall be liable for negligence, misfeasance,
537 nonfeasance, or malpractice in connection with the furnishing
538 of such services and supplies.

539 (e) Nothing in this chapter shall be construed in any
540 way to repeal or conflict with any provision of the
541 certificate of need law.

542 (f) Notwithstanding the provisions of subsection (a), a
543 health maintenance organization shall be subject to all of the
544 following:

545 (1) Section 27-1-17.

546 (2) Chapter 56.

547 (3) Chapter 54.

548 (4) Chapter 57.

549 (5) Chapter 58.

550 (6) Chapter 59.

551 (7) Rules adopted by the Commissioner of Insurance
552 pursuant to Sections 27-7-43 and 27-7-44.

553 (8) Chapter 12A.

554 (9) Chapter 54A.

555 (10) Chapter 2B.

556 (11) Chapter 29.

557 (12) Chapter 62.

558 (13) Chapter 63.

559 (14) Chapter 45A.

560 (15) Chapter 50A."



561 Section 3. Sections 16-25A-6 and 36-29-5, Code of
562 Alabama 1975, are amended to read as follows:

563 "§16-25A-6

564 ~~Such health insurance~~ The Public Education Employees'
565 Health Insurance Plan shall not include coverage for any of
566 the following:

567 (1) Expenses incurred by or on account of an individual
568 prior to the effective date of the planas to him;

569 (2) Hearing aids and examinations for the prescription
570 or fitting thereof+.

571 (3) Cosmetic surgery or treatment, except to the extent
572 necessary for correction of damage caused by accidental injury
573 or for breast reconstruction as required pursuant to Section
574 16-25A-6.1while covered by the plan, or as a direct result of
575 disease covered by the plan+.

576 (4) Services received in a hospital owned or operated
577 by the United States government for which no charge is made+.

578 (5) Services received for injury or sickness due to war
579 or any act of war, whether declared or undeclared, which war
580 or act of war shall have occurred after the effective date of
581 this plan+.

582 (6) Expenses for which the individual is not required
583 to make payment+.

584 (7) Expenses to the extent of benefits provided under
585 any employer group plan other than this plan in which the
586 state participates in the cost thereof+.

587 (8) Such other expenses as may be excluded by
588 regulationsrule of the board;and



589 (9) Coordination of benefit of basic hospital/medical
590 coverage provided herein and any supplemental hospital
591 indemnity, cancer or dental coverage provided herein under the
592 provisions of this article or as may privately be purchased by
593 any employee."

594 "§36-29-5

595 (a) ~~Such health insurance~~ The State Employees' Health
596 Insurance Plan shall not include coverage for any of the
597 following:

598 (1) Expenses incurred by or on account of an individual
599 prior to the effective date of the plan.

600 (2) Cosmetic surgery or treatment, except to the extent
601 necessary for correction of damages caused by accidental
602 injury or for breast reconstruction as required pursuant to
603 Section 36-29-4.1~~while covered by the plan~~, or as a direct
604 result of disease covered by the plan.

605 (3) Services received in a hospital owned or operated
606 by the United States government for which no charge is made.

607 (4) Services received for injury or sickness due to war
608 or any act of war, whether declared or undeclared, which war
609 or act of war shall have occurred after the effective date of
610 this plan.

611 (5) Expenses for which the individual is not required
612 to make payment.

613 (6) Expenses to the extent of benefits provided under
614 any employer group plan other than the plan in which the state
615 participates in the cost thereof.

616 (7) Such other expenses as may be excluded by



617 regulationsrule of the board.

618 (b) This section shall not mandate the coverage of
619 hearing assistance devices except that the State Employees'
620 Health Insurance Board may determine by a majority vote of the
621 board to cover such expenses in part or in whole on or after
622 April 11, 2000."

623 Section 4. Sections 16-25A-6.1, 22-6-11.1, and
624 36-29-4.1 are added to the Code of Alabama 1975, to read as
625 follows:

626 §16-25A-6.1

627 (a) On and after January 1, 2027, the Public Education
628 Employees' Health Insurance Plan shall provide coverage for
629 breast reconstruction subject to the same terms and conditions
630 as those provided in Chapter 50A of Title 27.

631 (b) If there is a conflict between this chapter and
632 Chapter 50A of Title 27, this chapter shall be given effect.

633 §22-6-11.1

634 (a) The Alabama Medicaid Agency shall provide coverage
635 for breast reconstruction as defined in Section 27-50A-2 to
636 any woman who is accepted for participation in a Medicaid
637 program for delivery of medical services which exists on the
638 effective date of this act.

639 (b) Breast reconstruction benefits shall commence on
640 and after January 1, 2027, and to the degree consistent with
641 this chapter, Medicaid rules, and policies, including those
642 governing Medicaid-approved providers, shall be according to
643 the same coverage provided in Chapter 50A of Title 27.

644 (c) The Alabama Medicaid Agency may adopt rules to

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645 implement this section.

646 §36-29-4.1

647 (a) On and after January 1, 2027, the State Employees'
648 Health Insurance Plan shall provide coverage for breast
649 reconstruction subject to the same terms and conditions as
650 those provided in Chapter 50A of Title 27.

651 (b) If there is a conflict between this chapter and
652 Chapter 50A of Title 27, this chapter shall be given effect.

653 Section 5. This act shall become effective on October
654 1, 2026.