

REFERENCE TITLE: insurance; cancer screening examinations.

State of Arizona
Senate
Forty-eighth Legislature
First Regular Session
2007

SB 1502

Introduced by
Senators Burton Cahill: Aboud, Hale

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1402, 20-1404, 20-2318 AND 20-2341, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-826.04; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.11; AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1342.06; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-1402.03 AND 20-1404.03; RELATING TO INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-826, Arizona Revised Statutes, is amended to
3 read:

4 20-826. Subscription contracts; definitions

5 A. A contract between a corporation and its subscribers shall not be
6 issued unless the form of such contract is approved in writing by the
7 director.

8 B. Each contract shall plainly state the services to which the
9 subscriber is entitled and those to which the subscriber is not entitled
10 under the plan, and shall constitute a direct obligation of the providers of
11 services with which the corporation has contracted for hospital, medical,
12 dental or optometric services.

13 C. Each contract, except for dental services or optometric services,
14 shall be so written that the corporation shall pay benefits for each of the
15 following:

16 1. Performance of any surgical service that is covered by the terms of
17 such contract, regardless of the place of service.

18 2. Any home health services that are performed by a licensed home
19 health agency and that a physician has prescribed in lieu of hospital
20 services, as defined by the director, providing the hospital services would
21 have been covered.

22 3. Any diagnostic service that a physician has performed outside a
23 hospital in lieu of inpatient service, providing the inpatient service would
24 have been covered.

25 4. Any service performed in a hospital's outpatient department or in a
26 freestanding surgical facility, if such service would have been covered if
27 performed as an inpatient service.

28 D. Each contract for dental or optometric services shall be so written
29 that the corporation shall pay benefits for contracted dental or optometric
30 services provided by dentists or optometrists.

31 E. Any contract, except accidental death and dismemberment, applied
32 for that provides family coverage ~~shall~~, as to such coverage of family
33 members, **SHALL** also provide that the benefits applicable for children shall
34 be payable with respect to a newly born child of the insured from the instant
35 of such child's birth, to a child adopted by the insured, regardless of the
36 age at which the child was adopted, and to a child who has been placed for
37 adoption with the insured and for whom the application and approval
38 procedures for adoption pursuant to section 8-105 or 8-108 have been
39 completed to the same extent that such coverage applies to other members of
40 the family. The coverage for newly born or adopted children or children
41 placed for adoption shall include coverage of injury or sickness, including
42 necessary care and treatment of medically diagnosed congenital defects and
43 birth abnormalities. If payment of a specific premium is required to provide
44 coverage for a child, the contract may require that notification of birth,
45 adoption or adoption placement of the child and payment of the required

1 premium must be furnished to the insurer within thirty-one days after the
2 date of birth, adoption or adoption placement in order to have the coverage
3 continue beyond the thirty-one day period.

4 F. Each contract that is delivered or issued for delivery in this
5 state after December 25, 1977 and that provides that coverage of a dependent
6 child shall terminate ~~upon~~ ON attainment of the limiting age for dependent
7 children specified in the contract shall also provide in substance that
8 attainment of such limiting age shall not operate to terminate the coverage
9 of such child while the child is and continues to be both incapable of
10 self-sustaining employment by reason of mental retardation or physical
11 handicap and chiefly dependent ~~upon~~ ON the subscriber for support and
12 maintenance. Proof of such incapacity and dependency shall be furnished to
13 the corporation by the subscriber within thirty-one days of the child's
14 attainment of the limiting age and subsequently as may be required by the
15 corporation, but not more frequently than annually after the two-year period
16 following the child's attainment of the limiting age.

17 G. No corporation may cancel or refuse to renew any subscriber's
18 contract without giving notice of such cancellation or nonrenewal to the
19 subscriber under such contract. A notice by the corporation to the
20 subscriber of cancellation or nonrenewal of a subscription contract shall be
21 mailed to the named subscriber at least forty-five days before the effective
22 date of such cancellation or nonrenewal. The notice shall include or be
23 accompanied by a statement in writing of the reasons for such action by the
24 corporation. Failure of the corporation to comply with ~~the provisions of~~
25 this subsection shall invalidate any cancellation or nonrenewal except a
26 cancellation or nonrenewal for nonpayment of premium.

27 H. A contract that provides coverage for surgical services for a
28 mastectomy shall also provide coverage incidental to the patient's covered
29 mastectomy for surgical services for reconstruction of the breast on which
30 the mastectomy was performed, surgery and reconstruction of the other breast
31 to produce a symmetrical appearance, prostheses, treatment of physical
32 complications for all stages of the mastectomy, including lymphedemas, and at
33 least two external postoperative prostheses subject to all of the terms and
34 conditions of the policy.

35 ~~I. A contract that provides coverage for surgical services for a~~
36 ~~mastectomy shall also provide coverage for mammography screening performed on~~
37 ~~dedicated equipment for diagnostic purposes on referral by a patient's~~
38 ~~physician, subject to all of the terms and conditions of the policy and~~
39 ~~according to the following guidelines:~~

40 ~~1. A baseline mammogram for a woman from age thirty-five to~~
41 ~~thirty-nine.~~

42 ~~2. A mammogram for a woman from age forty to forty-nine every two~~
43 ~~years or more frequently based on the recommendation of the woman's~~
44 ~~physician.~~

45 ~~3. A mammogram every year for a woman fifty years of age and over.~~

1 ~~J.~~ I. Any contract that is issued to the insured and that provides
2 coverage for maternity benefits shall also provide that the maternity
3 benefits apply to the costs of the birth of any child legally adopted by the
4 insured if all of the following are true:

- 5 1. The child is adopted within one year of birth.
- 6 2. The insured is legally obligated to pay the costs of birth.
- 7 3. All preexisting conditions and other limitations have been met by
8 the insured.
- 9 4. The insured has notified the insurer of the insured's acceptability
10 to adopt children pursuant to section 8-105, within sixty days after such
11 approval or within sixty days after a change in insurance policies, plans or
12 companies.

13 ~~K.~~ J. The coverage prescribed by subsection ~~J.~~ I of this section is
14 excess to any other coverage the natural mother may have for maternity
15 benefits except coverage made available to persons pursuant to title 36,
16 chapter 29 but not including coverage made available to persons defined as
17 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)
18 and (e). If such other coverage exists, the agency, attorney or individual
19 arranging the adoption shall make arrangements for the insurance to pay those
20 costs that may be covered under that policy and shall advise the adopting
21 parent in writing of the existence and extent of the coverage without
22 disclosing any confidential information such as the identity of the natural
23 parent. The insured adopting parents shall notify their insurer of the
24 existence and extent of the other coverage.

25 ~~L.~~ K. The director may disapprove any contract if the benefits
26 provided in the form of such contract are unreasonable in relation to the
27 premium charged.

28 ~~M.~~ L. The director shall adopt emergency rules **THAT ARE** applicable to
29 persons who are leaving active service in the armed forces of the United
30 States and returning to civilian status ~~including~~ **AND THAT INCLUDE:**

- 31 1. Conditions of eligibility.
- 32 2. Coverage of dependents.
- 33 3. Preexisting conditions.
- 34 4. Termination of insurance.
- 35 5. Probationary periods.
- 36 6. Limitations.
- 37 7. Exceptions.
- 38 8. Reductions.
- 39 9. Elimination periods.
- 40 10. Requirements for replacement.
- 41 11. Any other condition of subscription contracts.

1 ~~N~~. M. Any contract that provides maternity benefits shall not
2 restrict benefits for any hospital length of stay in connection with
3 childbirth for the mother or the newborn child to less than forty-eight hours
4 following a normal vaginal delivery or ninety-six hours following a cesarean
5 section. The contract shall not require the provider to obtain authorization
6 from the corporation for prescribing the minimum length of stay required by
7 this subsection. The contract may provide that an attending provider in
8 consultation with the mother may discharge the mother or the newborn child
9 before the expiration of the minimum length of stay required by this
10 subsection. The corporation shall not:

11 1. Deny the mother or the newborn child eligibility or continued
12 eligibility to enroll or to renew coverage under the terms of the contract
13 solely for the purpose of avoiding the requirements of this subsection.

14 2. Provide monetary payments or rebates to mothers to encourage those
15 mothers to accept less than the minimum protections available pursuant to
16 this subsection.

17 3. Penalize or otherwise reduce or limit the reimbursement of an
18 attending provider because that provider provided care to any insured under
19 the contract in accordance with this subsection.

20 4. Provide monetary or other incentives to an attending provider to
21 induce that provider to provide care to an insured under the contract in a
22 manner that is inconsistent with this subsection.

23 5. Except as described in subsection ~~⊖~~ N of this section, restrict
24 benefits for any portion of a period within the minimum length of stay in a
25 manner that is less favorable than the benefits provided for any preceding
26 portion of that stay.

27 ~~⊖~~. N. Nothing in subsection ~~N~~- M of this section:

28 1. Requires a mother to give birth in a hospital or to stay in the
29 hospital for a fixed period of time following the birth of the child.

30 2. Prevents a corporation from imposing deductibles, coinsurance or
31 other cost sharing in relation to benefits for hospital lengths of stay in
32 connection with childbirth for a mother or a newborn child under the
33 contract, except that any coinsurance or other cost sharing for any portion
34 of a period within a hospital length of stay required pursuant to subsection
35 ~~N~~- M of this section shall not be greater than the coinsurance or cost
36 sharing for any preceding portion of that stay.

37 3. Prevents a corporation from negotiating the level and type of
38 reimbursement with a provider for care provided in accordance with subsection
39 ~~N~~- M of this section.

40 ~~P~~. O. Any contract that provides coverage for diabetes shall also
41 provide coverage for equipment and supplies that are medically necessary and
42 that are prescribed by a health care provider, including:

43 1. Blood glucose monitors.

44 2. Blood glucose monitors for the legally blind.

1 3. Test strips for glucose monitors and visual reading and urine
2 testing strips.

3 4. Insulin preparations and glucagon.

4 5. Insulin cartridges.

5 6. Drawing up devices and monitors for the visually impaired.

6 7. Injection aids.

7 8. Insulin cartridges for the legally blind.

8 9. Syringes and lancets, including automatic lancing devices.

9 10. Prescribed oral agents for controlling blood sugar that are
10 included on the plan formulary.

11 11. To the extent coverage is required under medicare, podiatric
12 appliances for prevention of complications associated with diabetes.

13 12. Any other device, medication, equipment or supply for which
14 coverage is required under medicare from and after January 1, 1999. The
15 coverage required in this paragraph is effective six months after the
16 coverage is required under medicare.

17 ~~R~~ P. Nothing in subsection ~~P~~ 0 of this section prohibits a medical
18 service corporation, a hospital service corporation or a hospital, medical,
19 dental and optometric service corporation from imposing deductibles,
20 coinsurance or other cost sharing in relation to benefits for equipment or
21 supplies for the treatment of diabetes.

22 ~~R~~ Q. Any hospital or medical service contract that provides coverage
23 for prescription drugs shall not limit or exclude coverage for any
24 prescription drug prescribed for the treatment of cancer on the basis that
25 the prescription drug has not been approved by the United States food and
26 drug administration for the treatment of the specific type of cancer for
27 which the prescription drug has been prescribed, if the prescription drug has
28 been recognized as safe and effective for treatment of that specific type of
29 cancer in one or more of the standard medical reference compendia prescribed
30 in subsection ~~S~~ R of this section or medical literature that meets the
31 criteria prescribed in subsection ~~S~~ R of this section. The coverage
32 required under this subsection includes covered medically necessary services
33 associated with the administration of the prescription drug. This subsection
34 does not:

35 1. Require coverage of any prescription drug used in the treatment of
36 a type of cancer if the United States food and drug administration has
37 determined that the prescription drug is contraindicated for that type of
38 cancer.

39 2. Require coverage for any experimental prescription drug that is not
40 approved for any indication by the United States food and drug
41 administration.

42 3. Alter any law with regard to provisions that limit the coverage of
43 prescription drugs that have not been approved by the United States food and
44 drug administration.

1 4. Notwithstanding section 20-841.05, require reimbursement or
2 coverage for any prescription drug that is not included in the drug formulary
3 or list of covered prescription drugs specified in the contract.

4 5. Notwithstanding section 20-841.05, prohibit a contract from
5 limiting or excluding coverage of a prescription drug, if the decision to
6 limit or exclude coverage of the prescription drug is not based primarily on
7 the coverage of prescription drugs required by this section.

8 6. Prohibit the use of deductibles, coinsurance, copayments or other
9 cost sharing in relation to drug benefits and related medical benefits
10 offered.

11 ~~S.~~ R. For the purposes of subsection ~~R- Q~~ of this section:

12 1. The acceptable standard medical reference compendia are the
13 following:

14 (a) The American medical association drug evaluations, a publication
15 of the American medical association.

16 (b) The American hospital formulary service drug information, a
17 publication of the American society of health system pharmacists.

18 (c) Drug information for the health care provider, a publication of
19 the United States pharmacopoeia convention.

20 2. Medical literature may be accepted if all of the following apply:

21 (a) At least two articles from major peer reviewed professional
22 medical journals have recognized, based on scientific or medical criteria,
23 the drug's safety and effectiveness for treatment of the indication for which
24 the drug has been prescribed.

25 (b) No article from a major peer reviewed professional medical journal
26 has concluded, based on scientific or medical criteria, that the drug is
27 unsafe or ineffective or that the drug's safety and effectiveness cannot be
28 determined for the treatment of the indication for which the drug has been
29 prescribed.

30 (c) The literature meets the uniform requirements for manuscripts
31 submitted to biomedical journals established by the international committee
32 of medical journal editors or is published in a journal specified by the
33 United States department of health and human services as acceptable peer
34 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
35 security act (42 United States Code section 1395x(t)(2)(B)).

36 ~~T.~~ S. A corporation shall not issue or deliver any advertising matter
37 or sales material to any person in this state until the corporation files the
38 advertising matter or sales material with the director. This subsection does
39 not require a corporation to have the prior approval of the director to issue
40 or deliver the advertising matter or sales material. If the director finds
41 that the advertising matter or sales material, in whole or in part, is false,
42 deceptive or misleading, the director may issue an order disapproving the
43 advertising matter or sales material, directing the corporation to cease and
44 desist from issuing, circulating, displaying or using the advertising matter
45 or sales material within a period of time specified by the director but not

1 less than ten days and imposing any penalties prescribed in this title. At
 2 least five days before issuing an order pursuant to this subsection, the
 3 director shall provide the corporation with a written notice of the basis of
 4 the order to provide the corporation with an opportunity to cure the alleged
 5 deficiency in the advertising matter or sales material within a single five
 6 day period for the particular advertising matter or sales material at
 7 issue. The corporation may appeal the director's order pursuant to title 41,
 8 chapter 6, article 10. Except as otherwise provided in this subsection, a
 9 corporation may obtain a stay of the effectiveness of the order as prescribed
 10 in section 20-162. If the director certifies in the order and provides a
 11 detailed explanation of the reasons in support of the certification that
 12 continued use of the advertising matter or sales material poses a threat to
 13 the health, safety or welfare of the public, the order may be entered
 14 immediately without opportunity for cure and the effectiveness of the order
 15 is not stayed pending the hearing on the notice of appeal but the hearing
 16 shall be promptly instituted and determined.

17 ~~U.~~ T. Any contract that is offered by a hospital service corporation
 18 or medical service corporation and that contains a prescription drug benefit
 19 shall provide coverage of medical foods to treat inherited metabolic
 20 disorders as provided by this section.

21 ~~V.~~ U. The metabolic disorders triggering medical foods coverage under
 22 this section shall:

23 1. Be part of the newborn screening program prescribed in section
 24 36-694.

25 2. Involve amino acid, carbohydrate or fat metabolism.

26 3. Have medically standard methods of diagnosis, treatment and
 27 monitoring, including quantification of metabolites in blood, urine or spinal
 28 fluid or enzyme or DNA confirmation in tissues.

29 4. Require specially processed or treated medical foods that are
 30 generally available only under the supervision and direction of a physician
 31 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
 32 throughout life and without which the person may suffer serious mental or
 33 physical impairment.

34 ~~W.~~ V. Medical foods eligible for coverage under this section shall be
 35 prescribed or ordered under the supervision of a physician licensed pursuant
 36 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
 37 treatment of an inherited metabolic disease.

38 ~~X.~~ W. A hospital service corporation or medical service corporation
 39 shall cover at least fifty per cent of the cost of medical foods prescribed
 40 to treat inherited metabolic disorders and covered pursuant to this
 41 section. A hospital service corporation or medical service corporation may
 42 limit the maximum annual benefit for medical foods under this section to five
 43 thousand dollars, which applies to the cost of all prescribed modified low
 44 protein foods and metabolic formula.

1 ~~Y~~ X. Any contract between a corporation and its subscribers is
2 subject to the following:

3 1. If the contract provides coverage for prescription drugs, the
4 contract shall provide coverage for any prescribed drug or device that is
5 approved by the United States food and drug administration for use as a
6 contraceptive. A corporation may use a drug formulary, multitiered drug
7 formulary or list but that formulary or list shall include oral, implant and
8 injectable contraceptive drugs, intrauterine devices and prescription barrier
9 methods if the corporation does not impose deductibles, coinsurance,
10 copayments or other cost containment measures for contraceptive drugs that
11 are greater than the deductibles, coinsurance, copayments or other cost
12 containment measures for other drugs on the same level of the formulary or
13 list.

14 2. If the contract provides coverage for outpatient health care
15 services, the contract shall provide coverage for outpatient contraceptive
16 services. For the purposes of this paragraph, "outpatient contraceptive
17 services" means consultations, examinations, procedures and medical services
18 provided on an outpatient basis and related to the use of **APPROVED** United
19 States food and drug **ADMINISTRATION** prescription contraceptive methods to
20 prevent unintended pregnancies.

21 3. This subsection does not apply to contracts issued to individuals
22 on a nongroup basis.

23 ~~Z~~ Y. Notwithstanding subsection ~~Y~~ X of this section, a religious
24 employer whose religious tenets prohibit the use of prescribed contraceptive
25 methods may require that the corporation provide a contract without coverage
26 for all ~~federal~~ **UNITED STATES** food and drug administration approved
27 contraceptive methods. A religious employer shall submit a written affidavit
28 to the corporation stating that it is a religious employer. On receipt of
29 the affidavit, the corporation shall issue to the religious employer a
30 contract that excludes coverage of prescription contraceptive methods. The
31 corporation shall retain the affidavit for the duration of the contract and
32 any renewals of the contract. Before enrollment in the plan, every religious
33 employer that invokes this exemption shall provide prospective subscribers
34 written notice that the religious employer refuses to cover all ~~federal~~
35 **UNITED STATES** food and drug administration approved contraceptive methods for
36 religious reasons. This subsection shall not exclude coverage for
37 prescription contraceptive methods ordered by a health care provider with
38 prescriptive authority for medical indications other than to prevent an
39 unintended pregnancy. A corporation may require the subscriber to first pay
40 for the prescription and then submit a claim to the corporation along with
41 evidence that the prescription is for a noncontraceptive purpose. A
42 corporation may charge an administrative fee for handling these claims. A
43 religious employer shall not discriminate against an employee who
44 independently chooses to obtain insurance coverage or prescriptions for
45 contraceptives from another source.

1 ~~AA.~~ Z. For the purposes of:
2 1. This section:
3 (a) "Inherited metabolic disorder" means a disease caused by an
4 inherited abnormality of body chemistry and includes a disease tested under
5 the newborn screening program prescribed in section 36-694.
6 (b) "Medical foods" means modified low protein foods and metabolic
7 formula.
8 (c) "Metabolic formula" means foods that are all of the following:
9 (i) Formulated to be consumed or administered enterally under the
10 supervision of a physician who is licensed pursuant to title 32, chapter 13
11 or 17.
12 (ii) Processed or formulated to be deficient in one or more of the
13 nutrients present in typical foodstuffs.
14 (iii) Administered for the medical and nutritional management of a
15 person who has limited capacity to metabolize foodstuffs or certain nutrients
16 contained in the foodstuffs or who has other specific nutrient requirements
17 as established by medical evaluation.
18 (iv) Essential to a person's optimal growth, health and metabolic
19 homeostasis.
20 (d) "Modified low protein foods" means foods that are all of the
21 following:
22 (i) Formulated to be consumed or administered enterally under the
23 supervision of a physician who is licensed pursuant to title 32, chapter 13
24 or 17.
25 (ii) Processed or formulated to contain less than one gram of protein
26 per unit of serving, but does not include a natural food that is naturally
27 low in protein.
28 (iii) Administered for the medical and nutritional management of a
29 person who has limited capacity to metabolize foodstuffs or certain nutrients
30 contained in the foodstuffs or who has other specific nutrient requirements
31 as established by medical evaluation.
32 (iv) Essential to a person's optimal growth, health and metabolic
33 homeostasis.
34 2. Subsection E of this section, ~~the term~~ "child", for purposes of
35 initial coverage of an adopted child or a child placed for adoption but not
36 for purposes of termination of coverage of such child, means a person under
37 ~~the age of~~ eighteen years **OF AGE**.
38 3. Subsection ~~Z~~ Y of this section, "religious employer" means an
39 entity for which all of the following apply:
40 (a) The entity primarily employs persons who share the religious
41 tenets of the entity.
42 (b) The entity primarily serves persons who share the religious tenets
43 of the entity.

1 (c) The entity is a nonprofit organization as described in section
2 6033(a)(2)(A) ~~+~~ (i) or ~~+++~~ (iii) of the internal revenue code of 1986, as
3 amended.

4 Sec. 2. Title 20, chapter 4, article 3, Arizona Revised Statutes, is
5 amended by adding section 20-826.04, to read:

6 20-826.04. Subscription contracts: cancer screening
7 examinations; coverage

8 ANY CONTRACT THAT IS OFFERED BY A HOSPITAL SERVICE CORPORATION OR
9 MEDICAL SERVICE CORPORATION SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER
10 SCREENING EXAMINATIONS ON REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL
11 THE TERMS AND CONDITIONS OF THE CONTRACT AND ACCORDING TO THE FOLLOWING
12 GUIDELINES:

13 1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST
14 FIFTY YEARS OF AGE:

15 (a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.

16 (b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.

17 (c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.

18 (d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY
19 TEN YEARS.

20 2. MAMMOGRAPHY SCREENING:

21 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS
22 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.

23 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF
24 AGE.

25 3. BREAST CANCER SCREENING:

26 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH
27 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE
28 BUT WHO IS UNDER FORTY YEARS OF AGE.

29 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST
30 FORTY YEARS OF AGE.

31 4. CERVICAL CANCER SCREENING:

32 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS
33 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A
34 LIQUID-BASED PAP TEST.

35 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD
36 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILLOMAVIRUS TEST AND A
37 PAP TEST OR LIQUID-BASED PAP TEST.

38 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILLOMAVIRUS.

39 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT
40 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL
41 BIOPSY.

42 6. PROSTATE CANCER SCREENING:

43 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY
44 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.

1 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT
2 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST
3 AND A DIGITAL RECTAL EXAMINATION.

4 Sec. 3. Section 20-1057, Arizona Revised Statutes, is amended to read:
5 20-1057. Evidence of coverage by health care services
6 organizations; renewability; definitions

7 A. Every enrollee in a health care plan shall be issued an evidence of
8 coverage by the responsible health care services organization.

9 B. Any contract, except accidental death and dismemberment, applied
10 for that provides family coverage ~~shall~~, as to such coverage of family
11 members, SHALL also provide that the benefits applicable for children shall
12 be payable with respect to a newly born child of the enrollee from the
13 instant of such child's birth, to a child adopted by the enrollee, regardless
14 of the age at which the child was adopted, and to a child who has been placed
15 for adoption with the enrollee and for whom the application and approval
16 procedures for adoption pursuant to section 8-105 or 8-108 have been
17 completed to the same extent that such coverage applies to other members of
18 the family. The coverage for newly born or adopted children or children
19 placed for adoption shall include coverage of injury or sickness, including
20 necessary care and treatment of medically diagnosed congenital defects and
21 birth abnormalities. If payment of a specific premium is required to provide
22 coverage for a child, the contract may require that notification of birth,
23 adoption or adoption placement of the child and payment of the required
24 premium must be furnished to the insurer within thirty-one days after the
25 date of birth, adoption or adoption placement in order to have the coverage
26 continue beyond the thirty-one day period.

27 C. Any contract, except accidental death and dismemberment, that
28 provides coverage for psychiatric, drug abuse or alcoholism services shall
29 require the health care services organization to provide reimbursement for
30 such services in accordance with the terms of the contract without regard to
31 whether the covered services are rendered in a psychiatric special hospital
32 or general hospital.

33 D. No evidence of coverage or amendment to the coverage shall be
34 issued or delivered to any person in this state until a copy of the form of
35 the evidence of coverage or amendment to the coverage has been filed with and
36 approved by the director.

37 E. An evidence of coverage shall contain a clear and complete
38 statement if a contract, or a reasonably complete summary if a certificate of
39 contract, of:

40 1. The health care services and the insurance or other benefits, if
41 any, to which the enrollee is entitled under the health care plan.

42 2. Any limitations of the services, kind of services, benefits or kind
43 of benefits to be provided, including any deductible or copayment feature.

44 3. Where and in what manner information is available as to how
45 services may be obtained.

1 4. The enrollee's obligation, if any, respecting charges for the
2 health care plan.

3 F. An evidence of coverage shall not contain provisions or statements
4 that are unjust, unfair, inequitable, misleading or deceptive, that encourage
5 misrepresentation or that are untrue.

6 G. The director shall approve any form of evidence of coverage if the
7 requirements of subsections E and F of this section are met. It is unlawful
8 to issue such form until approved. If the director does not disapprove any
9 such form within forty-five days after the filing of the form, it is deemed
10 approved. If the director disapproves a form of evidence of coverage, the
11 director shall notify the health care services organization. In the notice,
12 the director shall specify the reasons for the director's disapproval. The
13 director shall grant a hearing on such disapproval within fifteen days after
14 a request for a hearing in writing is received from the health care services
15 organization.

16 H. A health care services organization shall not cancel or refuse to
17 renew an enrollee's evidence of coverage that was issued on a group basis
18 without giving notice of the cancellation or nonrenewal to the enrollee and,
19 on request of the director, to the department of insurance. A notice by the
20 organization to the enrollee of cancellation or nonrenewal of the enrollee's
21 evidence of coverage shall be mailed to the enrollee at least sixty days
22 before the effective date of such cancellation or nonrenewal. The notice
23 shall include or be accompanied by a statement in writing of the reasons as
24 stated in the contract for such action by the organization. Failure of the
25 organization to comply with this subsection shall invalidate any cancellation
26 or nonrenewal except a cancellation or nonrenewal for nonpayment of premium,
27 for fraud or misrepresentation in the application or other enrollment
28 documents or for loss of eligibility as defined in the evidence of coverage.
29 A health care services organization shall not cancel an enrollee's evidence
30 of coverage issued on a group basis because of the enrollee's or dependent's
31 age, except for loss of eligibility as defined in the evidence of coverage,
32 sex, health status-related factor, national origin or frequency of
33 utilization of health care services of the enrollee. An evidence of coverage
34 issued on a group basis shall clearly delineate all terms under which the
35 health care services organization may cancel or refuse to renew an evidence
36 of coverage for an enrollee or dependent. Nothing in this subsection
37 prohibits the cancellation or nonrenewal of a health benefits plan contract
38 issued on a group basis for any of the reasons allowed in section 20-2309. A
39 health care services organization may cancel or nonrenew an evidence of
40 coverage issued to an individual on a nongroup basis only for the reasons
41 allowed by subsection ~~N~~- M of this section.

42 I. A health care plan that provides coverage for surgical services for
43 a mastectomy shall also provide coverage incidental to the patient's covered
44 mastectomy for surgical services for reconstruction of the breast on which
45 the mastectomy was performed, surgery and reconstruction of the other breast

1 to produce a symmetrical appearance, prostheses, treatment of physical
2 complications for all stages of the mastectomy, including lymphedemas, and at
3 least two external postoperative prostheses subject to all of the terms and
4 conditions of the policy.

5 ~~J. A contract that provides coverage for surgical services for a~~
6 ~~mastectomy shall also provide coverage for mammography screening performed on~~
7 ~~dedicated equipment for diagnostic purposes on referral by a patient's~~
8 ~~physician, subject to all of the terms and conditions of the policy and~~
9 ~~according to the following guidelines:~~

10 ~~1. A baseline mammogram for a woman from age thirty-five to~~
11 ~~thirty-nine.~~

12 ~~2. A mammogram for a woman from age forty to forty-nine every two~~
13 ~~years or more frequently based on the recommendation of the woman's~~
14 ~~physician.~~

15 ~~3. A mammogram every year for a woman fifty years of age and over.~~

16 ~~K.~~ J. Any contract that is issued to the enrollee and that provides
17 coverage for maternity benefits shall also provide that the maternity
18 benefits apply to the costs of the birth of any child legally adopted by the
19 enrollee if all the following are true:

20 1. The child is adopted within one year of birth.

21 2. The enrollee is legally obligated to pay the costs of birth.

22 3. All preexisting conditions and other limitations have been met and
23 all deductibles and copayments have been paid by the enrollee.

24 4. The enrollee has notified the insurer of the enrollee's
25 acceptability to adopt children pursuant to section 8-105 within sixty days
26 after such approval or within sixty days after a change in insurance
27 policies, plans or companies.

28 ~~L.~~ K. The coverage prescribed by subsection ~~K~~ J of this section is
29 excess to any other coverage the natural mother may have for maternity
30 benefits except coverage made available to persons pursuant to title 36,
31 chapter 29 but not including coverage made available to persons defined as
32 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)
33 and (e). If such other coverage exists, the agency, attorney or individual
34 arranging the adoption shall make arrangements for the insurance to pay those
35 costs that may be covered under that policy and shall advise the adopting
36 parent in writing of the existence and extent of the coverage without
37 disclosing any confidential information such as the identity of the natural
38 parent. The enrollee adopting parents shall notify their health care
39 services organization of the existence and extent of the other coverage. A
40 health care services organization is not required to pay any costs in excess
41 of the amounts it would have been obligated to pay to its hospitals and
42 providers if the natural mother and child had received the maternity and
43 newborn care directly from or through that health care services organization.

1 ~~M.~~ L. Each health care services organization shall offer membership
2 to the following in a conversion plan that provides the basic health care
3 benefits required by the director:

4 1. Each enrollee including the enrollee's enrolled dependents leaving
5 a group.

6 2. Each enrollee and the enrollee's dependents who would otherwise
7 cease to be eligible for membership because of the age of the enrollee or the
8 enrollee's dependents or the death or the dissolution of marriage of an
9 enrollee.

10 ~~N.~~ M. A health care services organization shall not cancel or
11 nonrenew an evidence of coverage issued to an individual on a nongroup basis,
12 including a conversion plan, except for any of the following reasons and in
13 compliance with the notice and disclosure requirements contained in
14 subsection H of this section:

15 1. The individual has failed to pay premiums or contributions in
16 accordance with the terms of the evidence of coverage or the health care
17 services organization has not received premium payments in a timely manner.

18 2. The individual has performed an act or practice that constitutes
19 fraud or the individual made an intentional misrepresentation of material
20 fact under the terms of the evidence of coverage.

21 3. The health care services organization has ceased to offer coverage
22 to individuals that is consistent with the requirements of sections 20-1379
23 and 20-1380.

24 4. If the health care services organization offers a health care plan
25 in this state through a network plan, the individual no longer resides, lives
26 or works in the service area served by the network plan or in an area for
27 which the health care services organization is authorized to transact
28 business but only if the coverage is terminated uniformly without regard to
29 any health status-related factor of the covered individual.

30 5. If the health care services organization offers health coverage in
31 this state in the individual market only through one or more bona fide
32 associations, the membership of the individual in the association has ceased
33 but only if that coverage is terminated uniformly without regard to any
34 health status-related factor of any covered individual.

35 ~~O.~~ N. A conversion plan may be modified if the modification complies
36 with the notice and disclosure provisions for cancellation and nonrenewal
37 under subsection H of this section. A modification of a conversion plan that
38 has already been issued shall not result in the effective elimination of any
39 benefit originally included in the conversion plan.

40 ~~P.~~ O. Any person who is a United States armed forces reservist, who
41 is ordered to active military duty on or after August 22, 1990 and who was
42 enrolled in a health care plan shall have the right to reinstate such
43 coverage ~~upon~~ ON release from active military duty subject to the following
44 conditions:

1 1. The reservist shall make written application to the health plan
2 within ninety days of discharge from active military duty or within one year
3 of hospitalization continuing after discharge. Coverage shall be effective
4 ~~upon~~ ON receipt of the application by the health plan.

5 2. The health plan may exclude from such coverage any health or
6 physical condition arising during and occurring as a direct result of active
7 military duty.

8 ~~P.~~ P. The director shall adopt emergency rules THAT ARE applicable to
9 persons who are leaving active service in the armed forces of the United
10 States and returning to civilian status consistent with ~~the provisions of~~
11 subsection ~~P- 0~~ of this section ~~including~~ AND THAT INCLUDE:

- 12 1. Conditions of eligibility.
- 13 2. Coverage of dependents.
- 14 3. Preexisting conditions.
- 15 4. Termination of insurance.
- 16 5. Probationary periods.
- 17 6. Limitations.
- 18 7. Exceptions.
- 19 8. Reductions.
- 20 9. Elimination periods.
- 21 10. Requirements for replacement.
- 22 11. Any other conditions of evidences of coverage.

23 ~~R.~~ Q. Any contract that provides maternity benefits shall not
24 restrict benefits for any hospital length of stay in connection with
25 childbirth for the mother or the newborn child to less than forty-eight hours
26 following a normal vaginal delivery or ninety-six hours following a cesarean
27 section. The contract shall not require the provider to obtain authorization
28 from the health care services organization for prescribing the minimum length
29 of stay required by this subsection. The contract may provide that an
30 attending provider in consultation with the mother may discharge the mother
31 or the newborn child before the expiration of the minimum length of stay
32 required by this subsection. The health care services organization shall
33 not:

- 34 1. Deny the mother or the newborn child eligibility or continued
35 eligibility to enroll or to renew coverage under the terms of the contract
36 solely for the purpose of avoiding the requirements of this subsection.
- 37 2. Provide monetary payments or rebates to mothers to encourage those
38 mothers to accept less than the minimum protections available pursuant to
39 this subsection.
- 40 3. Penalize or otherwise reduce or limit the reimbursement of an
41 attending provider because that provider provided care to any insured under
42 the contract in accordance with this subsection.
- 43 4. Provide monetary or other incentives to an attending provider to
44 induce that provider to provide care to an insured under the contract in a
45 manner that is inconsistent with this subsection.

1 5. Except as described in subsection ~~S~~ R of this section, restrict
2 benefits for any portion of a period within the minimum length of stay in a
3 manner that is less favorable than the benefits provided for any preceding
4 portion of that stay.

5 ~~S~~ R. Nothing in subsection ~~R~~ Q of this section:

6 1. Requires a mother to give birth in a hospital or to stay in the
7 hospital for a fixed period of time following the birth of the child.

8 2. Prevents a health care services organization from imposing
9 deductibles, coinsurance or other cost sharing in relation to benefits for
10 hospital lengths of stay in connection with childbirth for a mother or a
11 newborn child under the contract, except that any coinsurance or other cost
12 sharing for any portion of a period within a hospital length of stay required
13 pursuant to subsection ~~R~~ Q of this section shall not be greater than the
14 coinsurance or cost sharing for any preceding portion of that stay.

15 3. Prevents a health care services organization from negotiating the
16 level and type of reimbursement with a provider for care provided in
17 accordance with subsection ~~R~~ Q of this section.

18 ~~T~~ S. Any contract or evidence of coverage that provides coverage for
19 diabetes shall also provide coverage for equipment and supplies that are
20 medically necessary and that are prescribed by a health care provider,
21 including:

22 1. Blood glucose monitors.

23 2. Blood glucose monitors for the legally blind.

24 3. Test strips for glucose monitors and visual reading and urine
25 testing strips.

26 4. Insulin preparations and glucagon.

27 5. Insulin cartridges.

28 6. Drawing up devices and monitors for the visually impaired.

29 7. Injection aids.

30 8. Insulin cartridges for the legally blind.

31 9. Syringes and lancets, including automatic lancing devices.

32 10. Prescribed oral agents for controlling blood sugar that are
33 included on the plan formulary.

34 11. To the extent coverage is required under medicare, podiatric
35 appliances for prevention of complications associated with diabetes.

36 12. Any other device, medication, equipment or supply for which
37 coverage is required under medicare from and after January 1, 1999. The
38 coverage required in this paragraph is effective six months after the
39 coverage is required under medicare.

40 ~~U~~ T. Nothing in subsection ~~T~~ S of this section:

41 1. Entitles a member or enrollee of a health care services
42 organization to equipment or supplies for the treatment of diabetes that are
43 not medically necessary as determined by the health care services
44 organization medical director or the medical director's designee.

1 2. Provides coverage for diabetic supplies obtained by a member or
2 enrollee of a health care services organization without a prescription unless
3 otherwise permitted pursuant to the terms of the health care plan.

4 3. Prohibits a health care services organization from imposing
5 deductibles, coinsurance or other cost sharing in relation to benefits for
6 equipment or supplies for the treatment of diabetes.

7 ~~V~~ U. Any contract or evidence of coverage that provides coverage for
8 prescription drugs shall not limit or exclude coverage for any prescription
9 drug prescribed for the treatment of cancer on the basis that the
10 prescription drug has not been approved by the United States food and drug
11 administration for the treatment of the specific type of cancer for which the
12 prescription drug has been prescribed, if the prescription drug has been
13 recognized as safe and effective for treatment of that specific type of
14 cancer in one or more of the standard medical reference compendia prescribed
15 in subsection ~~W~~ V of this section or medical literature that meets the
16 criteria prescribed in subsection ~~W~~ V of this section. The coverage
17 required under this subsection includes covered medically necessary services
18 associated with the administration of the prescription drug. This subsection
19 does not:

20 1. Require coverage of any prescription drug used in the treatment of
21 a type of cancer if the United States food and drug administration has
22 determined that the prescription drug is contraindicated for that type of
23 cancer.

24 2. Require coverage for any experimental prescription drug that is not
25 approved for any indication by the United States food and drug
26 administration.

27 3. Alter any law with regard to provisions that limit the coverage of
28 prescription drugs that have not been approved by the United States food and
29 drug administration.

30 4. Notwithstanding section 20-1057.02, require reimbursement or
31 coverage for any prescription drug that is not included in the drug formulary
32 or list of covered prescription drugs specified in the contract or evidence
33 of coverage.

34 5. Notwithstanding section 20-1057.02, prohibit a contract or evidence
35 of coverage from limiting or excluding coverage of a prescription drug, if
36 the decision to limit or exclude coverage of the prescription drug is not
37 based primarily on the coverage of prescription drugs required by this
38 section.

39 6. Prohibit the use of deductibles, coinsurance, copayments or other
40 cost sharing in relation to drug benefits and related medical benefits
41 offered.

42 ~~W~~ V. For the purposes of subsection ~~V~~ U of this section:

43 1. The acceptable standard medical reference compendia are the
44 following:

1 (a) The American medical association drug evaluations, a publication
2 of the American medical association.

3 (b) The American hospital formulary service drug information, a
4 publication of the American society of health system pharmacists.

5 (c) Drug information for the health care provider, a publication of
6 the United States pharmacopoeia convention.

7 2. Medical literature may be accepted if all of the following apply:

8 (a) At least two articles from major peer reviewed professional
9 medical journals have recognized, based on scientific or medical criteria,
10 the drug's safety and effectiveness for treatment of the indication for which
11 the drug has been prescribed.

12 (b) No article from a major peer reviewed professional medical journal
13 has concluded, based on scientific or medical criteria, that the drug is
14 unsafe or ineffective or that the drug's safety and effectiveness cannot be
15 determined for the treatment of the indication for which the drug has been
16 prescribed.

17 (c) The literature meets the uniform requirements for manuscripts
18 submitted to biomedical journals established by the international committee
19 of medical journal editors or is published in a journal specified by the
20 United States department of health and human services as acceptable peer
21 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
22 security act (42 United States Code section 1395x(t)(2)(B)).

23 ~~X~~ W. A health care services organization shall not issue or deliver
24 any advertising matter or sales material to any person in this state until
25 the health care services organization files the advertising matter or sales
26 material with the director. This subsection does not require a health care
27 services organization to have the prior approval of the director to issue or
28 deliver the advertising matter or sales material. If the director finds that
29 the advertising matter or sales material, in whole or in part, is false,
30 deceptive or misleading, the director may issue an order disapproving the
31 advertising matter or sales material, directing the health care services
32 organization to cease and desist from issuing, circulating, displaying or
33 using the advertising matter or sales material within a period of time
34 specified by the director but not less than ten days and imposing any
35 penalties prescribed in this title. At least five days before issuing an
36 order pursuant to this subsection, the director shall provide the health care
37 services organization with a written notice of the basis of the order to
38 provide the health care services organization with an opportunity to cure the
39 alleged deficiency in the advertising matter or sales material within a
40 single five day period for the particular advertising matter or sales
41 material at issue. The health care services organization may appeal the
42 director's order pursuant to title 41, chapter 6, article 10. Except as
43 otherwise provided in this subsection, a health care services organization
44 may obtain a stay of the effectiveness of the order as prescribed in section
45 20-162. If the director certifies in the order and provides a detailed

1 explanation of the reasons in support of the certification that continued use
2 of the advertising matter or sales material poses a threat to the health,
3 safety or welfare of the public, the order may be entered immediately without
4 opportunity for cure and the effectiveness of the order is not stayed pending
5 the hearing on the notice of appeal but the hearing shall be promptly
6 instituted and determined.

7 ~~Y.~~ X. Any contract or evidence of coverage that is offered by a
8 health care services organization and that contains a prescription drug
9 benefit shall provide coverage of medical foods to treat inherited metabolic
10 disorders as provided by this section.

11 ~~Z.~~ Y. The metabolic disorders triggering medical foods coverage under
12 this section shall:

13 1. Be part of the newborn screening program prescribed in section
14 36-694.

15 2. Involve amino acid, carbohydrate or fat metabolism.

16 3. Have medically standard methods of diagnosis, treatment and
17 monitoring, including quantification of metabolites in blood, urine or spinal
18 fluid or enzyme or DNA confirmation in tissues.

19 4. Require specially processed or treated medical foods that are
20 generally available only under the supervision and direction of a physician
21 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
22 throughout life and without which the person may suffer serious mental or
23 physical impairment.

24 ~~AA.~~ Z. Medical foods eligible for coverage under this section shall
25 be prescribed or ordered under the supervision of a physician licensed
26 pursuant to title 32, chapter 13 or 17 as medically necessary for the
27 therapeutic treatment of an inherited metabolic disease.

28 ~~BB.~~ AA. A health care services organization shall cover at least
29 fifty per cent of the cost of medical foods prescribed to treat inherited
30 metabolic disorders and covered pursuant to this section. An organization
31 may limit the maximum annual benefit for medical foods under this section to
32 five thousand dollars, which applies to the cost of all prescribed modified
33 low protein foods and metabolic formula.

34 ~~CC.~~ BB. Unless preempted under federal law or unless federal law
35 imposes greater requirements than this section, this section applies to a
36 provider sponsored health care services organization.

37 ~~DD.~~ CC. For the purposes of:

38 1. This section:

39 (a) "Inherited metabolic disorder" means a disease caused by an
40 inherited abnormality of body chemistry and includes a disease tested under
41 the newborn screening program prescribed in section 36-694.

42 (b) "Medical foods" means modified low protein foods and metabolic
43 formula.

44 (c) "Metabolic formula" means foods that are all of the following:

1 (i) Formulated to be consumed or administered enterally under the
2 supervision of a physician who is licensed pursuant to title 32, chapter 13
3 or 17.

4 (ii) Processed or formulated to be deficient in one or more of the
5 nutrients present in typical foodstuffs.

6 (iii) Administered for the medical and nutritional management of a
7 person who has limited capacity to metabolize foodstuffs or certain nutrients
8 contained in the foodstuffs or who has other specific nutrient requirements
9 as established by medical evaluation.

10 (iv) Essential to a person's optimal growth, health and metabolic
11 homeostasis.

12 (d) "Modified low protein foods" means foods that are all of the
13 following:

14 (i) Formulated to be consumed or administered enterally under the
15 supervision of a physician who is licensed pursuant to title 32, chapter 13
16 or 17.

17 (ii) Processed or formulated to contain less than one gram of protein
18 per unit of serving, but does not include a natural food that is naturally
19 low in protein.

20 (iii) Administered for the medical and nutritional management of a
21 person who has limited capacity to metabolize foodstuffs or certain nutrients
22 contained in the foodstuffs or who has other specific nutrient requirements
23 as established by medical evaluation.

24 (iv) Essential to a person's optimal growth, health and metabolic
25 homeostasis.

26 2. Subsection B of this section, "child", for purposes of initial
27 coverage of an adopted child or a child placed for adoption but not for
28 purposes of termination of coverage of such child, means a person under ~~the~~
29 ~~age of~~ eighteen years **OF AGE**.

30 Sec. 4. Title 20, chapter 4, article 9, Arizona Revised Statutes, is
31 amended by adding section 20-1057.11, to read:

32 **20-1057.11. Health care services organizations; cancer**
33 **screening examinations; coverage**

34 **ANY CONTRACT OR EVIDENCE OF COVERAGE THAT IS OFFERED BY A HEALTH CARE**
35 **SERVICES CORPORATION SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER**
36 **SCREENING EXAMINATIONS ON REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL**
37 **THE TERMS AND CONDITIONS OF THE CONTRACT OR EVIDENCE OF COVERAGE AND**
38 **ACCORDING TO THE FOLLOWING GUIDELINES:**

39 **1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST**
40 **FIFTY YEARS OF AGE:**

41 **(a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.**

42 **(b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.**

43 **(c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.**

44 **(d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY**
45 **TEN YEARS.**

- 1 2. MAMMOGRAPHY SCREENING:
- 2 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS
- 3 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.
- 4 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF
- 5 AGE.
- 6 3. BREAST CANCER SCREENING:
- 7 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH
- 8 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE
- 9 BUT WHO IS UNDER FORTY YEARS OF AGE.
- 10 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST
- 11 FORTY YEARS OF AGE.
- 12 4. CERVICAL CANCER SCREENING:
- 13 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS
- 14 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A
- 15 LIQUID-BASED PAP TEST.
- 16 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD
- 17 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILLOMAVIRUS TEST AND A
- 18 PAP TEST OR LIQUID-BASED PAP TEST.
- 19 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILLOMAVIRUS.
- 20 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT
- 21 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL
- 22 BIOPSY.
- 23 6. PROSTATE CANCER SCREENING:
- 24 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY
- 25 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.
- 26 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT
- 27 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST
- 28 AND A DIGITAL RECTAL EXAMINATION.
- 29 Sec. 5. Section 20-1342, Arizona Revised Statutes, is amended to read:
- 30 20-1342. Scope and format of policy; definitions
- 31 A. A policy of disability insurance shall not be delivered or issued
- 32 for delivery to any person in this state unless it otherwise complies with
- 33 this title and complies with the following:
- 34 1. The entire money and other considerations shall be expressed in the
- 35 policy.
- 36 2. The time when the insurance takes effect and terminates shall be
- 37 expressed in the policy.
- 38 3. It shall purport to insure only one person, except that a policy
- 39 may insure, originally or by subsequent amendment, on the application of the
- 40 policyholder or the policyholder's spouse, any two or more eligible members
- 41 of that family, including husband, wife, dependent children or any children
- 42 under a specified age that does not exceed nineteen years and any other
- 43 person dependent upon the policyholder. Any policy, except accidental death
- 44 and dismemberment, applied for that provides family coverage ~~shall~~, as to
- 45 such coverage of family members, **SHALL** also provide that the benefits

1 applicable for children shall be payable with respect to a newly born child
2 of the insured from the instant of such child's birth, to a child adopted by
3 the insured, regardless of the age at which the child was adopted, and to a
4 child who has been placed for adoption with the insured and for whom the
5 application and approval procedures for adoption pursuant to section 8-105 or
6 8-108 have been completed to the same extent that such coverage applies to
7 other members of the family. The coverage for newly born or adopted children
8 or children placed for adoption shall include coverage of injury or sickness,
9 including necessary care and treatment of medically diagnosed congenital
10 defects and birth abnormalities. If payment of a specific premium is
11 required to provide coverage for a child, the policy may require that
12 notification of birth, adoption or adoption placement of the child and
13 payment of the required premium must be furnished to the insurer within
14 thirty-one days after the date of birth, adoption or adoption placement in
15 order to have the coverage continue beyond the thirty-one day period.

16 4. The style, arrangement and overall appearance of the policy shall
17 give no undue prominence to any portion of the text, and every printed
18 portion of the text of the policy and of any endorsements or attached papers
19 shall be plainly printed in light-faced type of a style in general use, the
20 size of which shall be uniform and not less than ten point with a lower case
21 unspaced alphabet length of not less than one hundred and twenty point.
22 "Text" shall include all printed matter except the name and address of the
23 insurer, name or title of the policy, the brief description, if any, and
24 captions and subcaptions.

25 5. The exceptions and reductions of indemnity shall be set forth in
26 the policy and, other than those contained in sections 20-1345 through
27 20-1368, shall be printed and, at the insurer's option, either included with
28 the benefit provision to which they apply or under an appropriate caption
29 such as "exceptions", or "exceptions and reductions", except that if an
30 exception or reduction specifically applies only to a particular benefit of
31 the policy, a statement of such exception or reduction shall be included with
32 the benefit provision to which it applies.

33 6. Each such form, including riders and endorsements, shall be
34 identified by a form number in the lower left-hand corner of the first page.

35 7. The policy shall contain no provision purporting to make any
36 portion of the charter, rules, constitution or bylaws of the insurer a part
37 of the policy unless such portion is set forth in full in the policy, except
38 in the case of the incorporation of, or reference to, a statement of rates or
39 classification of risks, or short-rate table filed with the director.

40 8. Each contract shall be so written that the corporation shall pay
41 benefits:

42 (a) For performance of any surgical service that is covered by the
43 terms of such contract, regardless of the place of service.

44 (b) For any home health services that are performed by a licensed home
45 health agency and that a physician has prescribed in lieu of hospital

1 services, as defined by the director, providing the hospital services would
2 have been covered.

3 (c) For any diagnostic service that a physician has performed outside
4 a hospital in lieu of inpatient service, providing the inpatient service
5 would have been covered.

6 (d) For any service performed in a hospital's outpatient department or
7 in a freestanding surgical facility, providing such service would have been
8 covered if performed as an inpatient service.

9 9. A disability insurance policy that provides coverage for the
10 surgical expense of a mastectomy shall also provide coverage incidental to
11 the patient's covered mastectomy for the expense of reconstructive surgery of
12 the breast on which the mastectomy was performed, surgery and reconstruction
13 of the other breast to produce a symmetrical appearance, prostheses,
14 treatment of physical complications for all stages of the mastectomy,
15 including lymphedemas, and at least two external postoperative prostheses
16 subject to all of the terms and conditions of the policy.

17 ~~10. A contract, except a supplemental contract covering a specified~~
18 ~~disease or other limited benefits, that provides coverage for surgical~~
19 ~~services for a mastectomy shall also provide coverage for mammography~~
20 ~~screening performed on dedicated equipment for diagnostic purposes on~~
21 ~~referral by a patient's physician, subject to all of the terms and conditions~~
22 ~~of the policy and according to the following guidelines:~~

23 ~~(a) A baseline mammogram for a woman from age thirty-five to~~
24 ~~thirty-nine.~~

25 ~~(b) A mammogram for a woman from age forty to forty nine every two~~
26 ~~years or more frequently based on the recommendation of the woman's~~
27 ~~physician.~~

28 ~~(c) A mammogram every year for a woman fifty years of age and over.~~

29 ~~11.~~ 10. Any contract that is issued to the insured and that provides
30 coverage for maternity benefits shall also provide that the maternity
31 benefits apply to the costs of the birth of any child legally adopted by the
32 insured if all the following are true:

33 (a) The child is adopted within one year of birth.

34 (b) The insured is legally obligated to pay the costs of birth.

35 (c) All preexisting conditions and other limitations have been met by
36 the insured.

37 (d) The insured has notified the insurer of the insured's
38 acceptability to adopt children pursuant to section 8-105, within sixty days
39 after such approval or within sixty days after a change in insurance
40 policies, plans or companies.

41 ~~12.~~ 11. The coverage prescribed by paragraph ~~11~~ 10 of this subsection
42 is excess to any other coverage the natural mother may have for maternity
43 benefits except coverage made available to persons pursuant to title 36,
44 chapter 29, but not including coverage made available to persons defined as
45 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)

1 and (e). If such other coverage exists, the agency, attorney or individual
2 arranging the adoption shall make arrangements for the insurance to pay those
3 costs that may be covered under that policy and shall advise the adopting
4 parent in writing of the existence and extent of the coverage without
5 disclosing any confidential information such as the identity of the natural
6 parent. The insured adopting parents shall notify their insurer of the
7 existence and extent of the other coverage.

8 B. Any contract that provides maternity benefits shall not restrict
9 benefits for any hospital length of stay in connection with childbirth for
10 the mother or the newborn child to less than forty-eight hours following a
11 normal vaginal delivery or ninety-six hours following a cesarean
12 section. The contract shall not require the provider to obtain authorization
13 from the insurer for prescribing the minimum length of stay required by this
14 subsection. The contract may provide that an attending provider in
15 consultation with the mother may discharge the mother or the newborn child
16 before the expiration of the minimum length of stay required by this
17 subsection. The insurer shall not:

18 1. Deny the mother or the newborn child eligibility or continued
19 eligibility to enroll or to renew coverage under the terms of the contract
20 solely for the purpose of avoiding the requirements of this subsection.

21 2. Provide monetary payments or rebates to mothers to encourage those
22 mothers to accept less than the minimum protections available pursuant to
23 this subsection.

24 3. Penalize or otherwise reduce or limit the reimbursement of an
25 attending provider because that provider provided care to any insured under
26 the contract in accordance with this subsection.

27 4. Provide monetary or other incentives to an attending provider to
28 induce that provider to provide care to an insured under the contract in a
29 manner that is inconsistent with this subsection.

30 5. Except as described in subsection C of this section, restrict
31 benefits for any portion of a period within the minimum length of stay in a
32 manner that is less favorable than the benefits provided for any preceding
33 portion of that stay.

34 C. Nothing in subsection B of this section:

35 1. Requires a mother to give birth in a hospital or to stay in the
36 hospital for a fixed period of time following the birth of the child.

37 2. Prevents an insurer from imposing deductibles, coinsurance or other
38 cost sharing in relation to benefits for hospital lengths of stay in
39 connection with childbirth for a mother or a newborn child under the
40 contract, except that any coinsurance or other cost sharing for any portion
41 of a period within a hospital length of stay required pursuant to subsection
42 B of this section shall not be greater than the coinsurance or cost sharing
43 for any preceding portion of that stay.

1 3. Prevents an insurer from negotiating the level and type of
2 reimbursement with a provider for care provided in accordance with subsection
3 B of this section.

4 D. Any contract that provides coverage for diabetes shall also provide
5 coverage for equipment and supplies that are medically necessary and that are
6 prescribed by a health care provider, including:

- 7 1. Blood glucose monitors.
- 8 2. Blood glucose monitors for the legally blind.
- 9 3. Test strips for glucose monitors and visual reading and urine
10 testing strips.
- 11 4. Insulin preparations and glucagon.
- 12 5. Insulin cartridges.
- 13 6. Drawing up devices and monitors for the visually impaired.
- 14 7. Injection aids.
- 15 8. Insulin cartridges for the legally blind.
- 16 9. Syringes and lancets, including automatic lancing devices.
- 17 10. Prescribed oral agents for controlling blood sugar that are
18 included on the plan formulary.

19 11. To the extent coverage is required under medicare, podiatric
20 appliances for prevention of complications associated with diabetes.

21 12. Any other device, medication, equipment or supply for which
22 coverage is required under medicare from and after January 1, 1999. The
23 coverage required in this paragraph is effective six months after the
24 coverage is required under medicare.

25 E. Nothing in subsection D of this section:

26 1. Prohibits a disability insurer from imposing deductibles,
27 coinsurance or other cost sharing in relation to benefits for equipment or
28 supplies for the treatment of diabetes.

29 2. Requires a policy to provide an insured with outpatient benefits if
30 the policy does not cover outpatient benefits.

31 F. Any contract that provides coverage for prescription drugs shall
32 not limit or exclude coverage for any prescription drug prescribed for the
33 treatment of cancer on the basis that the prescription drug has not been
34 approved by the United States food and drug administration for the treatment
35 of the specific type of cancer for which the prescription drug has been
36 prescribed, if the prescription drug has been recognized as safe and
37 effective for treatment of that specific type of cancer in one or more of the
38 standard medical reference compendia prescribed in subsection G of this
39 section or medical literature that meets the criteria prescribed in
40 subsection G of this section. The coverage required under this subsection
41 includes covered medically necessary services associated with the
42 administration of the prescription drug. This subsection does not:

43 1. Require coverage of any prescription drug used in the treatment of
44 a type of cancer if the United States food and drug administration has

1 determined that the prescription drug is contraindicated for that type of
2 cancer.

3 2. Require coverage for any experimental prescription drug that is not
4 approved for any indication by the United States food and drug
5 administration.

6 3. Alter any law with regard to provisions that limit the coverage of
7 prescription drugs that have not been approved by the United States food and
8 drug administration.

9 4. Require reimbursement or coverage for any prescription drug that is
10 not included in the drug formulary or list of covered prescription drugs
11 specified in the contract.

12 5. Prohibit a contract from limiting or excluding coverage of a
13 prescription drug, if the decision to limit or exclude coverage of the
14 prescription drug is not based primarily on the coverage of prescription
15 drugs required by this section.

16 6. Prohibit the use of deductibles, coinsurance, copayments or other
17 cost sharing in relation to drug benefits and related medical benefits
18 offered.

19 G. For the purposes of subsection F of this section:

20 1. The acceptable standard medical reference compendia are the
21 following:

22 (a) The American medical association drug evaluations, a publication
23 of the American medical association.

24 (b) The American hospital formulary service drug information, a
25 publication of the American society of health system pharmacists.

26 (c) Drug information for the health care provider, a publication of
27 the United States pharmacopoeia convention.

28 2. Medical literature may be accepted if all of the following apply:

29 (a) At least two articles from major peer reviewed professional
30 medical journals have recognized, based on scientific or medical criteria,
31 the drug's safety and effectiveness for treatment of the indication for which
32 the drug has been prescribed.

33 (b) No article from a major peer reviewed professional medical journal
34 has concluded, based on scientific or medical criteria, that the drug is
35 unsafe or ineffective or that the drug's safety and effectiveness cannot be
36 determined for the treatment of the indication for which the drug has been
37 prescribed.

38 (c) The literature meets the uniform requirements for manuscripts
39 submitted to biomedical journals established by the international committee
40 of medical journal editors or is published in a journal specified by the
41 United States department of health and human services as acceptable peer
42 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
43 security act (42 United States Code section 1395x(t)(2)(B)).

44 H. Any contract that is offered by a disability insurer and that
45 contains a routine outpatient prescription drug benefit shall provide

1 coverage of medical foods to treat inherited metabolic disorders as provided
2 by this section.

3 I. The metabolic disorders triggering medical foods coverage under
4 this section shall:

5 1. Be part of the newborn screening program prescribed in section
6 36-694.

7 2. Involve amino acid, carbohydrate or fat metabolism.

8 3. Have medically standard methods of diagnosis, treatment and
9 monitoring, including quantification of metabolites in blood, urine or spinal
10 fluid or enzyme or DNA confirmation in tissues.

11 4. Require specially processed or treated medical foods that are
12 generally available only under the supervision and direction of a physician
13 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
14 throughout life and without which the person may suffer serious mental or
15 physical impairment.

16 J. Medical foods eligible for coverage under this section shall be
17 prescribed or ordered under the supervision of a physician licensed pursuant
18 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
19 treatment of an inherited metabolic disease.

20 K. An insurer shall cover at least fifty per cent of the cost of
21 medical foods prescribed to treat inherited metabolic disorders and covered
22 pursuant to this section. An insurer may limit the maximum annual benefit
23 for medical foods under this section to five thousand dollars, which applies
24 to the cost of all prescribed modified low protein foods and metabolic
25 formula.

26 L. For the purposes of:

27 1. This section:

28 (a) "Inherited metabolic disorder" means a disease caused by an
29 inherited abnormality of body chemistry and includes a disease tested under
30 the newborn screening program prescribed in section 36-694.

31 (b) "Medical foods" means modified low protein foods and metabolic
32 formula.

33 (c) "Metabolic formula" means foods that are all of the following:

34 (i) Formulated to be consumed or administered enterally under the
35 supervision of a physician who is licensed pursuant to title 32, chapter 13
36 or 17.

37 (ii) Processed or formulated to be deficient in one or more of the
38 nutrients present in typical foodstuffs.

39 (iii) Administered for the medical and nutritional management of a
40 person who has limited capacity to metabolize foodstuffs or certain nutrients
41 contained in the foodstuffs or who has other specific nutrient requirements
42 as established by medical evaluation.

43 (iv) Essential to a person's optimal growth, health and metabolic
44 homeostasis.

1 (d) "Modified low protein foods" means foods that are all of the
2 following:

3 (i) Formulated to be consumed or administered enterally under the
4 supervision of a physician who is licensed pursuant to title 32, chapter 13
5 or 17.

6 (ii) Processed or formulated to contain less than one gram of protein
7 per unit of serving, but does not include a natural food that is naturally
8 low in protein.

9 (iii) Administered for the medical and nutritional management of a
10 person who has limited capacity to metabolize foodstuffs or certain nutrients
11 contained in the foodstuffs or who has other specific nutrient requirements
12 as established by medical evaluation.

13 (iv) Essential to a person's optimal growth, health and metabolic
14 homeostasis.

15 2. Subsection A of this section, ~~the term~~ "child", for purposes of
16 initial coverage of an adopted child or a child placed for adoption but not
17 for purposes of termination of coverage of such child, means a person under
18 ~~the age of~~ eighteen years OF AGE.

19 Sec. 6. Title 20, chapter 6, article 4, Arizona Revised Statutes, is
20 amended by adding section 20-1342.06, to read:

21 20-1342.06. Disability insurers; cancer screening examinations;
22 coverage

23 ANY POLICY OF DISABILITY INSURANCE THAT IS OFFERED BY A DISABILITY
24 INSURER SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER SCREENING
25 EXAMINATIONS ON REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL THE TERMS
26 AND CONDITIONS OF THE POLICY AND ACCORDING TO THE FOLLOWING GUIDELINES:

27 1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST
28 FIFTY YEARS OF AGE:

29 (a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.

30 (b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.

31 (c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.

32 (d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY
33 TEN YEARS.

34 2. MAMMOGRAPHY SCREENING:

35 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS
36 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.

37 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF
38 AGE.

39 3. BREAST CANCER SCREENING:

40 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH
41 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE
42 BUT WHO IS UNDER FORTY YEARS OF AGE.

43 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST
44 FORTY YEARS OF AGE.

45 4. CERVICAL CANCER SCREENING:

1 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS
2 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A
3 LIQUID-BASED PAP TEST.

4 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD
5 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILLOMAVIRUS TEST AND A
6 PAP TEST OR LIQUID-BASED PAP TEST.

7 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILLOMAVIRUS.

8 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT
9 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL
10 BIOPSY.

11 6. PROSTATE CANCER SCREENING:

12 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY
13 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.

14 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT
15 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST
16 AND A DIGITAL RECTAL EXAMINATION.

17 Sec. 7. Section 20-1402, Arizona Revised Statutes, is amended to read:
18 20-1402. Provisions of group disability policies; definitions

19 A. Each group disability policy shall contain in substance the
20 following provisions:

21 1. A provision that, in the absence of fraud, all statements made by
22 the policyholder or by any insured person shall be deemed representations and
23 not warranties, and that no statement made for the purpose of effecting
24 insurance shall avoid such insurance or reduce benefits unless contained in a
25 written instrument signed by the policyholder or the insured person, a copy
26 of which has been furnished to the policyholder or to the person or
27 beneficiary.

28 2. A provision that the insurer will furnish to the policyholder, for
29 delivery to each employee or member of the insured group, an individual
30 certificate setting forth in summary form a statement of the essential
31 features of the insurance coverage of the employee or member and to whom
32 benefits are payable. If dependents or family members are included in the
33 coverage, additional certificates need not be issued for delivery to the
34 dependents or family members. Any policy, except accidental death and
35 dismemberment, applied for that provides family coverage ~~shall~~, as to such
36 coverage of family members, **SHALL** also provide that the benefits applicable
37 for children shall be payable with respect to a newly born child of the
38 insured from the instant of such child's birth, to a child adopted by the
39 insured, regardless of the age at which the child was adopted, and to a child
40 who has been placed for adoption with the insured and for whom the
41 application and approval procedures for adoption pursuant to section 8-105 or
42 8-108 have been completed to the same extent that such coverage applies to
43 other members of the family. The coverage for newly born or adopted children
44 or children placed for adoption shall include coverage of injury or sickness,
45 including the necessary care and treatment of medically diagnosed congenital

1 defects and birth abnormalities. If payment of a specific premium is
2 required to provide coverage for a child, the policy may require that
3 notification of birth, adoption or adoption placement of the child and
4 payment of the required premium must be furnished to the insurer within
5 thirty-one days after the date of birth, adoption or adoption placement in
6 order to have the coverage continue beyond such thirty-one day period.

7 3. A provision that to the group originally insured may be added from
8 time to time eligible new employees or members or dependents, as the case may
9 be, in accordance with the terms of the policy.

10 4. Each contract shall be so written that the corporation shall pay
11 benefits:

12 (a) For performance of any surgical service that is covered by the
13 terms of such contract, regardless of the place of service.

14 (b) For any home health services that are performed by a licensed home
15 health agency and that a physician has prescribed in lieu of hospital
16 services, as defined by the director, providing the hospital services would
17 have been covered.

18 (c) For any diagnostic service that a physician has performed outside
19 a hospital in lieu of inpatient service, providing the inpatient service
20 would have been covered.

21 (d) For any service performed in a hospital's outpatient department or
22 in a freestanding surgical facility, providing such service would have been
23 covered if performed as an inpatient service.

24 5. A group disability insurance policy that provides coverage for the
25 surgical expense of a mastectomy shall also provide coverage incidental to
26 the patient's covered mastectomy for the expense of reconstructive surgery of
27 the breast on which the mastectomy was performed, surgery and reconstruction
28 of the other breast to produce a symmetrical appearance, prostheses,
29 treatment of physical complications for all stages of the mastectomy,
30 including lymphedemas, and at least two external postoperative prostheses
31 subject to all of the terms and conditions of the policy.

32 ~~6. A contract, except a supplemental contract covering a specified~~
33 ~~disease or other limited benefits, that provides coverage for surgical~~
34 ~~services for a mastectomy shall also provide coverage for mammography~~
35 ~~screening performed on dedicated equipment for diagnostic purposes on~~
36 ~~referral by a patient's physician, subject to all of the terms and conditions~~
37 ~~of the policy and according to the following guidelines:~~

38 ~~(a) A baseline mammogram for a woman from age thirty-five to~~
39 ~~thirty-nine.~~

40 ~~(b) A mammogram for a woman from age forty to forty-nine every two~~
41 ~~years or more frequently based on the recommendation of the woman's~~
42 ~~physician.~~

43 ~~(c) A mammogram every year for a woman fifty years of age and over.~~

44 ~~7.~~ 6. Any contract that is issued to the insured and that provides
45 coverage for maternity benefits shall also provide that the maternity

1 benefits apply to the costs of the birth of any child legally adopted by the
2 insured if all the following are true:

3 (a) The child is adopted within one year of birth.

4 (b) The insured is legally obligated to pay the costs of birth.

5 (c) All preexisting conditions and other limitations have been met by
6 the insured.

7 (d) The insured has notified the insurer of the insured's
8 acceptability to adopt children pursuant to section 8-105, within sixty days
9 after such approval or within sixty days after a change in insurance
10 policies, plans or companies.

11 ~~8-~~ 7. The coverage prescribed by paragraph ~~7-~~ 6 of this subsection is
12 excess to any other coverage the natural mother may have for maternity
13 benefits except coverage made available to persons pursuant to title 36,
14 chapter 29, but not including coverage made available to persons defined as
15 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)
16 and (e). If such other coverage exists, the agency, attorney or individual
17 arranging the adoption shall make arrangements for the insurance to pay those
18 costs that may be covered under that policy and shall advise the adopting
19 parent in writing of the existence and extent of the coverage without
20 disclosing any confidential information such as the identity of the natural
21 parent. The insured adopting parents shall notify their insurer of the
22 existence and extent of the other coverage.

23 B. Any policy that provides maternity benefits shall not restrict
24 benefits for any hospital length of stay in connection with childbirth for
25 the mother or the newborn child to less than forty-eight hours following a
26 normal vaginal delivery or ninety-six hours following a cesarean
27 section. The policy shall not require the provider to obtain authorization
28 from the insurer for prescribing the minimum length of stay required by this
29 subsection. The policy may provide that an attending provider in
30 consultation with the mother may discharge the mother or the newborn child
31 before the expiration of the minimum length of stay required by this
32 subsection. The insurer shall not:

33 1. Deny the mother or the newborn child eligibility or continued
34 eligibility to enroll or to renew coverage under the terms of the policy
35 solely for the purpose of avoiding the requirements of this subsection.

36 2. Provide monetary payments or rebates to mothers to encourage those
37 mothers to accept less than the minimum protections available pursuant to
38 this subsection.

39 3. Penalize or otherwise reduce or limit the reimbursement of an
40 attending provider because that provider provided care to any insured under
41 the policy in accordance with this subsection.

42 4. Provide monetary or other incentives to an attending provider to
43 induce that provider to provide care to an insured under the policy in a
44 manner that is inconsistent with this subsection.

1 5. Except as described in subsection C of this section, restrict
2 benefits for any portion of a period within the minimum length of stay in a
3 manner that is less favorable than the benefits provided for any preceding
4 portion of that stay.

5 C. Nothing in subsection B of this section:

6 1. Requires a mother to give birth in a hospital or to stay in the
7 hospital for a fixed period of time following the birth of the child.

8 2. Prevents an insurer from imposing deductibles, coinsurance or other
9 cost sharing in relation to benefits for hospital lengths of stay in
10 connection with childbirth for a mother or a newborn child under the policy,
11 except that any coinsurance or other cost sharing for any portion of a period
12 within a hospital length of stay required pursuant to subsection B of this
13 section shall not be greater than the coinsurance or cost sharing for any
14 preceding portion of that stay.

15 3. Prevents an insurer from negotiating the level and type of
16 reimbursement with a provider for care provided in accordance with
17 subsection B of this section.

18 D. Any contract that provides coverage for diabetes shall also provide
19 coverage for equipment and supplies that are medically necessary and that are
20 prescribed by a health care provider, including:

21 1. Blood glucose monitors.

22 2. Blood glucose monitors for the legally blind.

23 3. Test strips for glucose monitors and visual reading and urine
24 testing strips.

25 4. Insulin preparations and glucagon.

26 5. Insulin cartridges.

27 6. Drawing up devices and monitors for the visually impaired.

28 7. Injection aids.

29 8. Insulin cartridges for the legally blind.

30 9. Syringes and lancets, including automatic lancing devices.

31 10. Prescribed oral agents for controlling blood sugar that are
32 included on the plan formulary.

33 11. To the extent coverage is required under medicare, podiatric
34 appliances for prevention of complications associated with diabetes.

35 12. Any other device, medication, equipment or supply for which
36 coverage is required under medicare from and after January 1, 1999. The
37 coverage required in this paragraph is effective six months after the
38 coverage is required under medicare.

39 E. Nothing in subsection D of this section prohibits a group
40 disability insurer from imposing deductibles, coinsurance or other cost
41 sharing in relation to benefits for equipment or supplies for the treatment
42 of diabetes.

43 F. Any contract that provides coverage for prescription drugs shall
44 not limit or exclude coverage for any prescription drug prescribed for the
45 treatment of cancer on the basis that the prescription drug has not been

1 approved by the United States food and drug administration for the treatment
2 of the specific type of cancer for which the prescription drug has been
3 prescribed, if the prescription drug has been recognized as safe and
4 effective for treatment of that specific type of cancer in one or more of the
5 standard medical reference compendia prescribed in subsection G of this
6 section or medical literature that meets the criteria prescribed in
7 subsection G of this section. The coverage required under this subsection
8 includes covered medically necessary services associated with the
9 administration of the prescription drug. This subsection does not:

10 1. Require coverage of any prescription drug used in the treatment of
11 a type of cancer if the United States food and drug administration has
12 determined that the prescription drug is contraindicated for that type of
13 cancer.

14 2. Require coverage for any experimental prescription drug that is not
15 approved for any indication by the United States food and drug
16 administration.

17 3. Alter any law with regard to provisions that limit the coverage of
18 prescription drugs that have not been approved by the United States food and
19 drug administration.

20 4. Require reimbursement or coverage for any prescription drug that is
21 not included in the drug formulary or list of covered prescription drugs
22 specified in the contract.

23 5. Prohibit a contract from limiting or excluding coverage of a
24 prescription drug, if the decision to limit or exclude coverage of the
25 prescription drug is not based primarily on the coverage of prescription
26 drugs required by this section.

27 6. Prohibit the use of deductibles, coinsurance, copayments or other
28 cost sharing in relation to drug benefits and related medical benefits
29 offered.

30 G. For the purposes of subsection F of this section:

31 1. The acceptable standard medical reference compendia are the
32 following:

33 (a) The American medical association drug evaluations, a publication
34 of the American medical association.

35 (b) The American hospital formulary service drug information, a
36 publication of the American society of health system pharmacists.

37 (c) Drug information for the health care provider, a publication of
38 the United States pharmacopoeia convention.

39 2. Medical literature may be accepted if all of the following apply:

40 (a) At least two articles from major peer reviewed professional
41 medical journals have recognized, based on scientific or medical criteria,
42 the drug's safety and effectiveness for treatment of the indication for which
43 the drug has been prescribed.

44 (b) No article from a major peer reviewed professional medical journal
45 has concluded, based on scientific or medical criteria, that the drug is

1 unsafe or ineffective or that the drug's safety and effectiveness cannot be
2 determined for the treatment of the indication for which the drug has been
3 prescribed.

4 (c) The literature meets the uniform requirements for manuscripts
5 submitted to biomedical journals established by the international committee
6 of medical journal editors or is published in a journal specified by the
7 United States department of health and human services as acceptable peer
8 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
9 security act (42 United States Code section 1395x(t)(2)(B)).

10 H. Any contract that is offered by a group disability insurer and that
11 contains a prescription drug benefit shall provide coverage of medical foods
12 to treat inherited metabolic disorders as provided by this section.

13 I. The metabolic disorders triggering medical foods coverage under
14 this section shall:

15 1. Be part of the newborn screening program prescribed in section
16 36-694.

17 2. Involve amino acid, carbohydrate or fat metabolism.

18 3. Have medically standard methods of diagnosis, treatment and
19 monitoring, including quantification of metabolites in blood, urine or spinal
20 fluid or enzyme or DNA confirmation in tissues.

21 4. Require specially processed or treated medical foods that are
22 generally available only under the supervision and direction of a physician
23 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
24 throughout life and without which the person may suffer serious mental or
25 physical impairment.

26 J. Medical foods eligible for coverage under this section shall be
27 prescribed or ordered under the supervision of a physician licensed pursuant
28 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
29 treatment of an inherited metabolic disease.

30 K. An insurer shall cover at least fifty per cent of the cost of
31 medical foods prescribed to treat inherited metabolic disorders and covered
32 pursuant to this section. An insurer may limit the maximum annual benefit
33 for medical foods under this section to five thousand dollars, which applies
34 to the cost of all prescribed modified low protein foods and metabolic
35 formula.

36 L. Any group disability policy that provides coverage for:

37 1. Prescription drugs shall also provide coverage for any prescribed
38 drug or device that is approved by the United States food and drug
39 administration for use as a contraceptive. A group disability insurer may
40 use a drug formulary, multitiered drug formulary or list but that formulary
41 or list shall include oral, implant and injectable contraceptive drugs,
42 intrauterine devices and prescription barrier methods if the group disability
43 insurer does not impose deductibles, coinsurance, copayments or other cost
44 containment measures for contraceptive drugs that are greater than the

1 deductibles, coinsurance, copayments or other cost containment measures for
2 other drugs on the same level of the formulary or list.

3 2. Outpatient health care services shall also provide coverage for
4 outpatient contraceptive services. For the purposes of this paragraph,
5 "outpatient contraceptive services" means consultations, examinations,
6 procedures and medical services provided on an outpatient basis and related
7 to the use of APPROVED United States food and drug ADMINISTRATION
8 prescription contraceptive methods to prevent unintended pregnancies.

9 M. Notwithstanding subsection L of this section, a religious employer
10 whose religious tenets prohibit the use of prescribed contraceptive methods
11 may require that the insurer provide a group disability policy without
12 coverage for all ~~federal~~ UNITED STATES food and drug administration approved
13 contraceptive methods. A religious employer shall submit a written affidavit
14 to the insurer stating that it is a religious employer. On receipt of the
15 affidavit, the insurer shall issue to the religious employer a group
16 disability policy that excludes coverage of prescription contraceptive
17 methods. The insurer shall retain the affidavit for the duration of the
18 group disability policy and any renewals of the policy. Before a policy is
19 issued, every religious employer that invokes this exemption shall provide
20 prospective insureds written notice that the religious employer refuses to
21 cover all ~~federal~~ UNITED STATES food and drug administration approved
22 contraceptive methods for religious reasons. This subsection shall not
23 exclude coverage for prescription contraceptive methods ordered by a health
24 care provider with prescriptive authority for medical indications other than
25 to prevent an unintended pregnancy. An insurer may require the insured to
26 first pay for the prescription and then submit a claim to the insurer along
27 with evidence that the prescription is for a noncontraceptive purpose. An
28 insurer may charge an administrative fee for handling these claims. A
29 religious employer shall not discriminate against an employee who
30 independently chooses to obtain insurance coverage or prescriptions for
31 contraceptives from another source.

32 N. For the purposes of:

33 1. This section:

34 (a) "Inherited metabolic disorder" means a disease caused by an
35 inherited abnormality of body chemistry and includes a disease tested under
36 the newborn screening program prescribed in section 36-694.

37 (b) "Medical foods" means modified low protein foods and metabolic
38 formula.

39 (c) "Metabolic formula" means foods that are all of the following:

40 (i) Formulated to be consumed or administered enterally under the
41 supervision of a physician who is licensed pursuant to title 32, chapter 13
42 or 17.

43 (ii) Processed or formulated to be deficient in one or more of the
44 nutrients present in typical foodstuffs.

1 (iii) Administered for the medical and nutritional management of a
2 person who has limited capacity to metabolize foodstuffs or certain nutrients
3 contained in the foodstuffs or who has other specific nutrient requirements
4 as established by medical evaluation.

5 (iv) Essential to a person's optimal growth, health and metabolic
6 homeostasis.

7 (d) "Modified low protein foods" means foods that are all of the
8 following:

9 (i) Formulated to be consumed or administered enterally under the
10 supervision of a physician who is licensed pursuant to title 32, chapter 13
11 or 17.

12 (ii) Processed or formulated to contain less than one gram of protein
13 per unit of serving, but does not include a natural food that is naturally
14 low in protein.

15 (iii) Administered for the medical and nutritional management of a
16 person who has limited capacity to metabolize foodstuffs or certain nutrients
17 contained in the foodstuffs or who has other specific nutrient requirements
18 as established by medical evaluation.

19 (iv) Essential to a person's optimal growth, health and metabolic
20 homeostasis.

21 2. Subsection A of this section, ~~the term~~ "child", for purposes of
22 initial coverage of an adopted child or a child placed for adoption but not
23 for purposes of termination of coverage of such child, means a person under
24 ~~the age of~~ eighteen years OF AGE.

25 3. Subsection M of this section, "religious employer" means an entity
26 for which all of the following apply:

27 (a) The entity primarily employs persons who share the religious
28 tenets of the entity.

29 (b) The entity serves primarily persons who share the religious tenets
30 of the entity.

31 (c) The entity is a nonprofit organization as described in section
32 6033(a)(2)(A) ~~+~~ (i) or ~~+++~~ (iii) of the internal revenue code of 1986, as
33 amended.

34 Sec. 8. Title 20, chapter 6, article 5, Arizona Revised Statutes, is
35 amended by adding section 20-1402.03, to read:

36 20-1402.03. Group disability insurers; cancer screening
37 examinations; coverage

38 ANY GROUP DISABILITY POLICY THAT IS OFFERED BY A GROUP DISABILITY
39 INSURER SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER SCREENING
40 EXAMINATIONS ON REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL THE TERMS
41 AND CONDITIONS OF THE POLICY AND ACCORDING TO THE FOLLOWING GUIDELINES:

42 1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST
43 FIFTY YEARS OF AGE:

44 (a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.

45 (b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.

- 1 (c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.
- 2 (d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY
- 3 TEN YEARS.
- 4 2. MAMMOGRAPHY SCREENING:
- 5 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS
- 6 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.
- 7 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF
- 8 AGE.
- 9 3. BREAST CANCER SCREENING:
- 10 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH
- 11 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE
- 12 BUT WHO IS UNDER FORTY YEARS OF AGE.
- 13 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST
- 14 FORTY YEARS OF AGE.
- 15 4. CERVICAL CANCER SCREENING:
- 16 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS
- 17 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A
- 18 LIQUID-BASED PAP TEST.
- 19 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD
- 20 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILLOMAVIRUS TEST AND A
- 21 PAP TEST OR LIQUID-BASED PAP TEST.
- 22 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILLOMAVIRUS.
- 23 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT
- 24 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL
- 25 BIOPSY.
- 26 6. PROSTATE CANCER SCREENING:
- 27 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY
- 28 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.
- 29 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT
- 30 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST
- 31 AND A DIGITAL RECTAL EXAMINATION.
- 32 Sec. 9. Section 20-1404, Arizona Revised Statutes, is amended to read:
- 33 20-1404. Blanket disability insurance; definitions
- 34 A. Blanket disability insurance is that form of disability insurance
- 35 covering special groups of persons as enumerated in one of the following
- 36 paragraphs:
- 37 1. Under a policy or contract issued to any common carrier, which
- 38 shall be deemed the policyholder, covering a group defined as all persons who
- 39 may become passengers on such common carrier.
- 40 2. Under a policy or contract issued to an employer, who shall be
- 41 deemed the policyholder, covering all employees or any group of employees
- 42 defined by reference to exceptional hazards incident to such employment.
- 43 Dependents of the employees and guests of the employer may also be included
- 44 where exposed to the same hazards.

1 3. Under a policy or contract issued to a college, school or other
2 institution of learning or to the head or principal thereof, who or which
3 shall be deemed the policyholder, covering students or teachers.

4 4. Under a policy or contract issued in the name of any volunteer fire
5 department or first aid or other such volunteer group, or agency having
6 jurisdiction thereof, which shall be deemed the policyholder, covering all of
7 the members of such fire department or group.

8 5. Under a policy or contract issued to a creditor, who shall be
9 deemed the policyholder, to insure debtors of the creditor.

10 6. Under a policy or contract issued to a sports team or to a camp or
11 sponsor thereof, which team or camp or sponsor thereof shall be deemed the
12 policyholder, covering members or campers.

13 7. Under a policy or contract that is issued to any other
14 substantially similar group and that, in the discretion of the director, may
15 be subject to the issuance of a blanket disability policy or contract.

16 B. An individual application need not be required from a person
17 covered under a blanket disability policy or contract, nor shall it be
18 necessary for the insurer to furnish each person with a certificate.

19 C. All benefits under any blanket disability policy shall be payable
20 to the person insured, or to the insured's designated beneficiary or
21 beneficiaries, or to the insured's estate, except that if the person insured
22 is a minor, such benefits may be made payable to the insured's parent or
23 guardian or any other person actually supporting the insured, and except that
24 the policy may provide that all or any portion of any indemnities provided by
25 any such policy on account of hospital, nursing, medical or surgical services
26 ~~may~~, at the insurer's option, ~~MAY~~ be paid directly to the hospital or person
27 rendering such services, but the policy may not require that the service be
28 rendered by a particular hospital or person. Payment so made shall discharge
29 the insurer's obligation with respect to the amount of insurance so paid.

30 D. Nothing contained in this section shall be deemed to affect the
31 legal liability of policyholders for the death of or injury to any member of
32 the group.

33 E. Any policy or contract, except accidental death and dismemberment,
34 applied for that provides family coverage ~~shall~~, as to such coverage of
35 family members, ~~SHALL~~ also provide that the benefits applicable for children
36 shall be payable with respect to a newly born child of the insured from the
37 instant of such child's birth, to a child adopted by the insured, regardless
38 of the age at which the child was adopted, and to a child who has been placed
39 for adoption with the insured and for whom the application and approval
40 procedures for adoption pursuant to section 8-105 or 8-108 have been
41 completed to the same extent that such coverage applies to other members of
42 the family. The coverage for newly born or adopted children or children
43 placed for adoption shall include coverage of injury or sickness, including
44 necessary care and treatment of medically diagnosed congenital defects and
45 birth abnormalities. If payment of a specific premium is required to provide

1 coverage for a child, the policy or contract may require that notification of
2 birth, adoption or adoption placement of the child and payment of the
3 required premium must be furnished to the insurer within thirty-one days
4 after the date of birth, adoption or adoption placement in order to have the
5 coverage continue beyond the thirty-one day period.

6 F. Each policy or contract shall be so written that the insurer shall
7 pay benefits:

8 1. For performance of any surgical service that is covered by the
9 terms of such contract, regardless of the place of service.

10 2. For any home health services that are performed by a licensed home
11 health agency and that a physician has prescribed in lieu of hospital
12 services, as defined by the director, providing the hospital services would
13 have been covered.

14 3. For any diagnostic service that a physician has performed outside a
15 hospital in lieu of inpatient service, providing the inpatient service would
16 have been covered.

17 4. For any service performed in a hospital's outpatient department or
18 in a freestanding surgical facility, providing such service would have been
19 covered if performed as an inpatient service.

20 G. A blanket disability insurance policy that provides coverage for
21 the surgical expense of a mastectomy shall also provide coverage incidental
22 to the patient's covered mastectomy for the expense of reconstructive surgery
23 of the breast on which the mastectomy was performed, surgery and
24 reconstruction of the other breast to produce a symmetrical appearance,
25 prostheses, treatment of physical complications for all stages of the
26 mastectomy, including lymphedemas, and at least two external postoperative
27 prostheses subject to all of the terms and conditions of the policy.

28 ~~H. A contract that provides coverage for surgical services for a
29 mastectomy shall also provide coverage for mammography screening performed on
30 dedicated equipment for diagnostic purposes on referral by a patient's
31 physician, subject to all of the terms and conditions of the policy and
32 according to the following guidelines:~~

33 ~~1. A baseline mammogram for a woman from age thirty five to
34 thirty nine.~~

35 ~~2. A mammogram for a woman from age forty to forty-nine every two
36 years or more frequently based on the recommendation of the woman's
37 physician.~~

38 ~~3. A mammogram every year for a woman fifty years of age and over.~~

39 I. H. Any contract that is issued to the insured and that provides
40 coverage for maternity benefits shall also provide that the maternity
41 benefits apply to the costs of the birth of any child legally adopted by the
42 insured if all the following are true:

43 1. The child is adopted within one year of birth.

44 2. The insured is legally obligated to pay the costs of birth.

1 3. All preexisting conditions and other limitations have been met by
2 the insured.

3 4. The insured has notified the insurer of his acceptability to adopt
4 children pursuant to section 8-105, within sixty days after such approval or
5 within sixty days after a change in insurance policies, plans or companies.

6 ~~J~~ I. The coverage prescribed by subsection ~~I~~ H of this section is
7 excess to any other coverage the natural mother may have for maternity
8 benefits except coverage made available to persons pursuant to title 36,
9 chapter 29, but not including coverage made available to persons defined as
10 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)
11 and (e). If such other coverage exists, the agency, attorney or individual
12 arranging the adoption shall make arrangements for the insurance to pay those
13 costs that may be covered under that policy and shall advise the adopting
14 parent in writing of the existence and extent of the coverage without
15 disclosing any confidential information such as the identity of the natural
16 parent. The insured adopting parents shall notify their insurer of the
17 existence and extent of the other coverage.

18 ~~K~~ J. Any contract that provides maternity benefits shall not
19 restrict benefits for any hospital length of stay in connection with
20 childbirth for the mother or the newborn child to less than forty-eight hours
21 following a normal vaginal delivery or ninety-six hours following a cesarean
22 section. The contract shall not require the provider to obtain authorization
23 from the insurer for prescribing the minimum length of stay required by this
24 subsection. The contract may provide that an attending provider in
25 consultation with the mother may discharge the mother or the newborn child
26 before the expiration of the minimum length of stay required by this
27 subsection. The insurer shall not:

28 1. Deny the mother or the newborn child eligibility or continued
29 eligibility to enroll or to renew coverage under the terms of the contract
30 solely for the purpose of avoiding the requirements of this subsection.

31 2. Provide monetary payments or rebates to mothers to encourage those
32 mothers to accept less than the minimum protections available pursuant to
33 this subsection.

34 3. Penalize or otherwise reduce or limit the reimbursement of an
35 attending provider because that provider provided care to any insured under
36 the contract in accordance with this subsection.

37 4. Provide monetary or other incentives to an attending provider to
38 induce that provider to provide care to an insured under the contract in a
39 manner that is inconsistent with this subsection.

40 5. Except as described in subsection ~~L~~ K of this section, restrict
41 benefits for any portion of a period within the minimum length of stay in a
42 manner that is less favorable than the benefits provided for any preceding
43 portion of that stay.

44 ~~L~~ K. Nothing in subsection ~~K~~ J of this section:

1 1. Requires a mother to give birth in a hospital or to stay in the
2 hospital for a fixed period of time following the birth of the child.

3 2. Prevents an insurer from imposing deductibles, coinsurance or other
4 cost sharing in relation to benefits for hospital lengths of stay in
5 connection with childbirth for a mother or a newborn child under the
6 contract, except that any coinsurance or other cost sharing for any portion
7 of a period within a hospital length of stay required pursuant to subsection
8 ~~K~~ J of this section shall not be greater than the coinsurance or cost
9 sharing for any preceding portion of that stay.

10 3. Prevents an insurer from negotiating the level and type of
11 reimbursement with a provider for care provided in accordance with subsection
12 ~~K~~ J of this section.

13 ~~M~~. L. Any contract that provides coverage for diabetes shall also
14 provide coverage for equipment and supplies that are medically necessary and
15 that are prescribed by a health care provider, including:

- 16 1. Blood glucose monitors.
- 17 2. Blood glucose monitors for the legally blind.
- 18 3. Test strips for glucose monitors and visual reading and urine
19 testing strips.
- 20 4. Insulin preparations and glucagon.
- 21 5. Insulin cartridges.
- 22 6. Drawing up devices and monitors for the visually impaired.
- 23 7. Injection aids.
- 24 8. Insulin cartridges for the legally blind.
- 25 9. Syringes and lancets, including automatic lancing devices.
- 26 10. Prescribed oral agents for controlling blood sugar that are
27 included on the plan formulary.
- 28 11. To the extent coverage is required under medicare, podiatric
29 appliances for prevention of complications associated with diabetes.
- 30 12. Any other device, medication, equipment or supply for which
31 coverage is required under medicare from and after January 1, 1999. The
32 coverage required in this paragraph is effective six months after the
33 coverage is required under medicare.

34 ~~N~~. M. Nothing in subsection ~~M~~ L of this section prohibits a blanket
35 disability insurer from imposing deductibles, coinsurance or other cost
36 sharing in relation to benefits for equipment or supplies for the treatment
37 of diabetes.

38 ~~O~~. N. Any contract that provides coverage for prescription drugs
39 shall not limit or exclude coverage for any prescription drug prescribed for
40 the treatment of cancer on the basis that the prescription drug has not been
41 approved by the United States food and drug administration for the treatment
42 of the specific type of cancer for which the prescription drug has been
43 prescribed, if the prescription drug has been recognized as safe and
44 effective for treatment of that specific type of cancer in one or more of the
45 standard medical reference compendia prescribed in subsection ~~P~~ O of this

1 section or medical literature that meets the criteria prescribed in
2 subsection ~~P~~- 0 of this section. The coverage required under this subsection
3 includes covered medically necessary services associated with the
4 administration of the prescription drug. This subsection does not:

5 1. Require coverage of any prescription drug used in the treatment of
6 a type of cancer if the United States food and drug administration has
7 determined that the prescription drug is contraindicated for that type of
8 cancer.

9 2. Require coverage for any experimental prescription drug that is not
10 approved for any indication by the United States food and drug
11 administration.

12 3. Alter any law with regard to provisions that limit the coverage of
13 prescription drugs that have not been approved by the United States food and
14 drug administration.

15 4. Require reimbursement or coverage for any prescription drug that is
16 not included in the drug formulary or list of covered prescription drugs
17 specified in the contract.

18 5. Prohibit a contract from limiting or excluding coverage of a
19 prescription drug, if the decision to limit or exclude coverage of the
20 prescription drug is not based primarily on the coverage of prescription
21 drugs required by this section.

22 6. Prohibit the use of deductibles, coinsurance, copayments or other
23 cost sharing in relation to drug benefits and related medical benefits
24 offered.

25 ~~P~~- 0. For the purposes of subsection ~~0~~- N of this section:

26 1. The acceptable standard medical reference compendia are the
27 following:

28 (a) The American medical association drug evaluations, a publication
29 of the American medical association.

30 (b) The American hospital formulary service drug information, a
31 publication of the American society of health system pharmacists.

32 (c) Drug information for the health care provider, a publication of
33 the United States pharmacopoeia convention.

34 2. Medical literature may be accepted if all of the following apply:

35 (a) At least two articles from major peer reviewed professional
36 medical journals have recognized, based on scientific or medical criteria,
37 the drug's safety and effectiveness for treatment of the indication for which
38 the drug has been prescribed.

39 (b) No article from a major peer reviewed professional medical journal
40 has concluded, based on scientific or medical criteria, that the drug is
41 unsafe or ineffective or that the drug's safety and effectiveness cannot be
42 determined for the treatment of the indication for which the drug has been
43 prescribed.

44 (c) The literature meets the uniform requirements for manuscripts
45 submitted to biomedical journals established by the international committee

1 of medical journal editors or is published in a journal specified by the
2 United States department of health and human services as acceptable peer
3 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
4 security act (42 United States Code section 1395x(t)(2)(B)).

5 ~~Q.~~ P. Any contract that is offered by a blanket disability insurer
6 and that contains a prescription drug benefit shall provide coverage of
7 medical foods to treat inherited metabolic disorders as provided by this
8 section.

9 ~~R.~~ Q. The metabolic disorders triggering medical foods coverage under
10 this section shall:

11 1. Be part of the newborn screening program prescribed in section
12 36-694.

13 2. Involve amino acid, carbohydrate or fat metabolism.

14 3. Have medically standard methods of diagnosis, treatment and
15 monitoring, including quantification of metabolites in blood, urine or spinal
16 fluid or enzyme or DNA confirmation in tissues.

17 4. Require specially processed or treated medical foods that are
18 generally available only under the supervision and direction of a physician
19 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
20 throughout life and without which the person may suffer serious mental or
21 physical impairment.

22 ~~S.~~ R. Medical foods eligible for coverage under this section shall be
23 prescribed or ordered under the supervision of a physician licensed pursuant
24 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
25 treatment of an inherited metabolic disease.

26 ~~T.~~ S. An insurer shall cover at least fifty per cent of the cost of
27 medical foods prescribed to treat inherited metabolic disorders and covered
28 pursuant to this section. An insurer may limit the maximum annual benefit
29 for medical foods under this section to five thousand dollars, which applies
30 to the cost of all prescribed modified low protein foods and metabolic
31 formula.

32 ~~U.~~ T. Any blanket disability policy that provides coverage for:

33 1. Prescription drugs shall also provide coverage for any prescribed
34 drug or device that is approved by the United States food and drug
35 administration for use as a contraceptive. A blanket disability insurer may
36 use a drug formulary, multitiered drug formulary or list but that formulary
37 or list shall include oral, implant and injectable contraceptive drugs,
38 intrauterine devices and prescription barrier methods if the blanket
39 disability insurer does not impose deductibles, coinsurance, copayments or
40 other cost containment measures for contraceptive drugs that are greater than
41 the deductibles, coinsurance, copayments or other cost containment measures
42 for other drugs on the same level of the formulary or list.

43 2. Outpatient health care services shall also provide coverage for
44 outpatient contraceptive services. For the purposes of this paragraph,
45 "outpatient contraceptive services" means consultations, examinations,

1 procedures and medical services provided on an outpatient basis and related
 2 to the use of APPROVED United States food and drug ADMINISTRATION
 3 prescription contraceptive methods to prevent unintended pregnancies.

4 ~~V.~~ U. Notwithstanding subsection ~~U.~~ T of this section, a religious
 5 employer whose religious tenets prohibit the use of prescribed contraceptive
 6 methods may require that the insurer provide a blanket disability policy
 7 without coverage for all ~~federal~~ UNITED STATES food and drug administration
 8 approved contraceptive methods. A religious employer shall submit a written
 9 affidavit to the insurer stating that it is a religious employer. On receipt
 10 of the affidavit, the insurer shall issue to the religious employer a blanket
 11 disability policy that excludes coverage of prescription contraceptive
 12 methods. The insurer shall retain the affidavit for the duration of the
 13 blanket disability policy and any renewals of the policy. Before a policy is
 14 issued, every religious employer that invokes this exemption shall provide
 15 prospective insureds written notice that the religious employer refuses to
 16 cover all ~~federal~~ UNITED STATES food and drug administration approved
 17 contraceptive methods for religious reasons. This subsection shall not
 18 exclude coverage for prescription contraceptive methods ordered by a health
 19 care provider with prescriptive authority for medical indications other than
 20 to prevent an unintended pregnancy. An insurer may require the insured to
 21 first pay for the prescription and then submit a claim to the insurer along
 22 with evidence that the prescription is for a noncontraceptive purpose. An
 23 insurer may charge an administrative fee for handling these claims under this
 24 ~~paragraph~~ SUBSECTION. A religious employer shall not discriminate against an
 25 employee who independently chooses to obtain insurance coverage or
 26 prescriptions for contraceptives from another source.

27 ~~W.~~ V. For the purposes of:

28 1. This section:

29 (a) "Inherited metabolic disorder" means a disease caused by an
 30 inherited abnormality of body chemistry and includes a disease tested under
 31 the newborn screening program prescribed in section 36-694.

32 (b) "Medical foods" means modified low protein foods and metabolic
 33 formula.

34 (c) "Metabolic formula" means foods that are all of the following:

35 (i) Formulated to be consumed or administered enterally under the
 36 supervision of a physician who is licensed pursuant to title 32, chapter 13
 37 or 17.

38 (ii) Processed or formulated to be deficient in one or more of the
 39 nutrients present in typical foodstuffs.

40 (iii) Administered for the medical and nutritional management of a
 41 person who has limited capacity to metabolize foodstuffs or certain nutrients
 42 contained in the foodstuffs or who has other specific nutrient requirements
 43 as established by medical evaluation.

44 (iv) Essential to a person's optimal growth, health and metabolic
 45 homeostasis.

1 (d) "Modified low protein foods" means foods that are all of the
2 following:

3 (i) Formulated to be consumed or administered enterally under the
4 supervision of a physician who is licensed pursuant to title 32, chapter 13
5 or 17.

6 (ii) Processed or formulated to contain less than one gram of protein
7 per unit of serving, but does not include a natural food that is naturally
8 low in protein.

9 (iii) Administered for the medical and nutritional management of a
10 person who has limited capacity to metabolize foodstuffs or certain nutrients
11 contained in the foodstuffs or who has other specific nutrient requirements
12 as established by medical evaluation.

13 (iv) Essential to a person's optimal growth, health and metabolic
14 homeostasis.

15 2. Subsection E of this section, ~~the term~~ "child", for purposes of
16 initial coverage of an adopted child or a child placed for adoption but not
17 for purposes of termination of coverage of such child, means a person under
18 ~~the age of~~ eighteen years OF AGE.

19 3. Subsection ~~V~~ U of this section, "religious employer" means an
20 entity for which all of the following apply:

21 (a) The entity primarily employs persons who share the religious
22 tenets of the entity.

23 (b) The entity serves primarily persons who share the religious tenets
24 of the entity.

25 (c) The entity is a nonprofit organization as described in section
26 6033(a)(2)(A) ~~+~~ (i) or ~~+~~ (iii) of the internal revenue code of 1986, as
27 amended.

28 Sec. 10. Title 20, chapter 6, article 5, Arizona Revised Statutes, is
29 amended by adding section 20-1404.03, to read:

30 20-1404.03. Blanket disability insurers: cancer screening
31 examinations: coverage

32 ANY POLICY OR CONTRACT THAT IS OFFERED BY A BLANKET DISABILITY INSURER
33 SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER SCREENING EXAMINATIONS ON
34 REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL THE TERMS AND CONDITIONS OF
35 THE POLICY OR CONTRACT AND ACCORDING TO THE FOLLOWING GUIDELINES:

36 1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST
37 FIFTY YEARS OF AGE:

38 (a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.

39 (b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.

40 (c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.

41 (d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY
42 TEN YEARS.

43 2. MAMMOGRAPHY SCREENING:

44 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS
45 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.

1 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF
2 AGE.

3 3. BREAST CANCER SCREENING:

4 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH
5 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE
6 BUT WHO IS UNDER FORTY YEARS OF AGE.

7 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST
8 FORTY YEARS OF AGE.

9 4. CERVICAL CANCER SCREENING:

10 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS
11 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A
12 LIQUID-BASED PAP TEST.

13 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD
14 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILOMAVIRUS TEST AND A
15 PAP TEST OR LIQUID-BASED PAP TEST.

16 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILOMAVIRUS.

17 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT
18 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL
19 BIOPSY.

20 6. PROSTATE CANCER SCREENING:

21 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY
22 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.

23 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT
24 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST
25 AND A DIGITAL RECTAL EXAMINATION.

26 Sec. 11. Section 20-2318, Arizona Revised Statutes, is amended to
27 read:

28 20-2318. Mandatory coverage prohibited

29 Notwithstanding any law to the contrary, the basic health benefit plan
30 is not subject to the requirements of:

- 31 1. Section 20-461, subsection A, paragraph ~~16~~ 17 and subsection B. ~~---~~
- 32 2. Section 20-826, subsections C, D, E, F, H, I, ~~---~~ AND J. ~~and K,~~
- 33 3. SECTION 20-826.04.
- 34 4. ~~Sections~~ SECTION 20-841. ~~---~~
- 35 5. SECTION 20-841.01. ~~and~~
- 36 6. SECTION 20-841.02. ~~---~~
- 37 7. Section 20-1051, paragraph 4. ~~---~~
- 38 8. Section 20-1057, subsections B, C, I, J, K, ~~---~~ AND L. ~~and M,~~
- 39 9. SECTION 20-1057.11.
- 40 10. Section 20-1402, subsection A, paragraphs 2, 4, 5, 6, ~~---~~ AND 7.
- 41 ~~and 8,~~
- 42 11. SECTION 20-1402.03.
- 43 12. Section 20-1404, subsections E, F, G, H, ~~---~~ AND I. ~~and J and~~
- 44 13. SECTION 20-1404.03.
- 45 14. ~~Sections~~ SECTION 20-1406. ~~---~~

1 2. "Small business" means a business that employed at least two but
2 not more than twenty-five persons at any time during the most recent calendar
3 year and that has been uninsured for at least six months.

4 Sec. 13. Application

5 This act applies to contracts, policies and evidences of coverage
6 issued or renewed from and after December 31, 2007.