

State of Arizona  
House of Representatives  
Fiftieth Legislature  
Second Regular Session  
2012

# HOUSE BILL 2625

AN ACT

AMENDING SECTIONS 20-826, 20-1057.08, 20-1402, 20-1404 AND 20-2329, ARIZONA  
REVISED STATUTES; RELATING TO HEALTH 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, as to such coverage of family members,  
33 shall also provide that the benefits applicable for children shall be payable  
34 with respect to a newly born child of the insured from the instant of such  
35 child's birth, to a child adopted by the insured, regardless of the age at  
36 which the child was adopted, and to a child who has been placed for adoption  
37 with the insured and for whom the application and approval procedures for  
38 adoption pursuant to section 8-105 or 8-108 have been completed to the same  
39 extent that such coverage applies to other members of the family. The  
40 coverage for newly born or adopted children or children placed for adoption  
41 shall include coverage of injury or sickness, including necessary care and  
42 treatment of medically diagnosed congenital defects and birth abnormalities.  
43 If payment of a specific premium is required to provide coverage for a child,  
44 the contract may require that notification of birth, adoption or adoption  
45 placement of the child and payment of the required premium must be furnished

1 to the insurer within thirty-one days after the date of birth, adoption or  
2 adoption placement in order to have the coverage continue beyond the  
3 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 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 intellectual disability or physical  
11 handicap and chiefly dependent on the subscriber for support and maintenance.  
12 Proof of such incapacity and dependency shall be furnished to the corporation  
13 by the subscriber within thirty-one days of the child's attainment of the  
14 limiting age and subsequently as may be required by the corporation, but not  
15 more frequently than annually after the two-year period following the child's  
16 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 this subsection shall  
25 invalidate any cancellation or nonrenewal except a cancellation or nonrenewal  
26 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. 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. The coverage prescribed by subsection J of this section is excess  
14 to any other coverage the natural mother may have for maternity benefits  
15 except coverage made available to persons pursuant to title 36, chapter 29  
16 but not including coverage made available to persons defined as eligible  
17 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
18 such other coverage exists, the agency, attorney or individual arranging the  
19 adoption shall make arrangements for the insurance to pay those costs that  
20 may be covered under that policy and shall advise the adopting parent in  
21 writing of the existence and extent of the coverage without disclosing any  
22 confidential information such as the identity of the natural parent. The  
23 insured adopting parents shall notify their insurer of the existence and  
24 extent of the other coverage.

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

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

- 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.

42 N. Any contract that provides maternity benefits shall not restrict  
43 benefits for any hospital length of stay in connection with childbirth for  
44 the mother or the newborn child to less than forty-eight hours following a  
45 normal vaginal delivery or ninety-six hours following a cesarean section.

1 The contract shall not require the provider to obtain authorization from the  
2 corporation for prescribing the minimum length of stay required by this  
3 subsection. The contract may provide that an attending provider in  
4 consultation with the mother may discharge the mother or the newborn child  
5 before the expiration of the minimum length of stay required by this  
6 subsection. The corporation shall not:

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

10 2. Provide monetary payments or rebates to mothers to encourage those  
11 mothers to accept less than the minimum protections available pursuant to  
12 this subsection.

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

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

19 5. Except as described in subsection O of this section, restrict  
20 benefits for any portion of a period within the minimum length of stay in a  
21 manner that is less favorable than the benefits provided for any preceding  
22 portion of that stay.

23 O. Nothing in subsection N of this section:

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

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

33 3. Prevents a corporation from negotiating the level and type of  
34 reimbursement with a provider for care provided in accordance with subsection  
35 N of this section.

36 P. Any contract that provides coverage for diabetes shall also provide  
37 coverage for equipment and supplies that are medically necessary and that are  
38 prescribed by a health care provider, including:

39 1. Blood glucose monitors.

40 2. Blood glucose monitors for the legally blind.

41 3. Test strips for glucose monitors and visual reading and urine  
42 testing strips.

43 4. Insulin preparations and glucagon.

44 5. Insulin cartridges.

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

1           7. Injection aids.

2           8. Insulin cartridges for the legally blind.

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

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

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

8           12. Any other device, medication, equipment or supply for which  
9 coverage is required under medicare from and after January 1, 1999. The  
10 coverage required in this paragraph is effective six months after the  
11 coverage is required under medicare.

12           Q. Nothing in subsection P of this section prohibits a medical service  
13 corporation, a hospital service corporation or a hospital, medical, dental  
14 and optometric service corporation from imposing deductibles, coinsurance or  
15 other cost sharing in relation to benefits for equipment or supplies for the  
16 treatment of diabetes.

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

29           1. Require coverage of any prescription drug used in the treatment of  
30 a type of cancer if the United States food and drug administration has  
31 determined that the prescription drug is contraindicated for that type of  
32 cancer.

33           2. Require coverage for any experimental prescription drug that is not  
34 approved for any indication by the United States food and drug  
35 administration.

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

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

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

1           6. Prohibit the use of deductibles, coinsurance, copayments or other  
2 cost sharing in relation to drug benefits and related medical benefits  
3 offered.

4           S. For the purposes of subsection R of this section:

5           1. The acceptable standard medical reference compendia are the  
6 following:

7           (a) The American hospital formulary service drug information, a  
8 publication of the American society of health system pharmacists.

9           (b) The national comprehensive cancer network drugs and biologics  
10 compendium.

11           (c) Thomson Micromedex compendium DrugDex.

12           (d) Elsevier gold standard's clinical pharmacology compendium.

13           (e) Other authoritative compendia as identified by the secretary of  
14 the United States department of health and human services.

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

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

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

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

31           T. A corporation shall not issue or deliver any advertising matter or  
32 sales material to any person in this state until the corporation files the  
33 advertising matter or sales material with the director. This subsection does  
34 not require a corporation to have the prior approval of the director to issue  
35 or deliver the advertising matter or sales material. If the director finds  
36 that the advertising matter or sales material, in whole or in part, is false,  
37 deceptive or misleading, the director may issue an order disapproving the  
38 advertising matter or sales material, directing the corporation to cease and  
39 desist from issuing, circulating, displaying or using the advertising matter  
40 or sales material within a period of time specified by the director but not  
41 less than ten days and imposing any penalties prescribed in this title. At  
42 least five days before issuing an order pursuant to this subsection, the  
43 director shall provide the corporation with a written notice of the basis of  
44 the order to provide the corporation with an opportunity to cure the alleged  
45 deficiency in the advertising matter or sales material within a single five

1 day period for the particular advertising matter or sales material at issue.  
2 The corporation may appeal the director's order pursuant to title 41,  
3 chapter 6, article 10. Except as otherwise provided in this subsection, a  
4 corporation may obtain a stay of the effectiveness of the order as prescribed  
5 in section 20-162. If the director certifies in the order and provides a  
6 detailed explanation of the reasons in support of the certification that  
7 continued use of the advertising matter or sales material poses a threat to  
8 the health, safety or welfare of the public, the order may be entered  
9 immediately without opportunity for cure and the effectiveness of the order  
10 is not stayed pending the hearing on the notice of appeal but the hearing  
11 shall be promptly instituted and determined.

12 U. Any contract that is offered by a hospital service corporation or  
13 medical service corporation and that contains a prescription drug benefit  
14 shall provide coverage of medical foods to treat inherited metabolic  
15 disorders as provided by this section.

16 V. The metabolic disorders triggering medical foods coverage under  
17 this section shall:

18 1. Be part of the newborn screening program prescribed in section  
19 36-694.

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

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

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

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

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

41 Y. Any contract between a corporation and its subscribers is subject  
42 to the following:

43 1. If the contract provides coverage for prescription drugs, the  
44 contract shall provide coverage for any prescribed drug or device that is  
45 approved by the United States food and drug administration for use as a

1 contraceptive. A corporation may use a drug formulary, multitiered drug  
2 formulary or list but that formulary or list shall include oral, implant and  
3 injectable contraceptive drugs, intrauterine devices and prescription barrier  
4 methods if the corporation does not impose deductibles, coinsurance,  
5 copayments or other cost containment measures for contraceptive drugs that  
6 are greater than the deductibles, coinsurance, copayments or other cost  
7 containment measures for other drugs on the same level of the formulary or  
8 list.

9 2. If the contract provides coverage for outpatient health care  
10 services, the contract shall provide coverage for outpatient contraceptive  
11 services. For the purposes of this paragraph, "outpatient contraceptive  
12 services" means consultations, examinations, procedures and medical services  
13 provided on an outpatient basis and related to the use of approved United  
14 States food and drug administration prescription contraceptive methods to  
15 prevent unintended pregnancies.

16 3. This subsection does not apply to contracts issued to individuals  
17 on a nongroup basis.

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

40 Z. NOTWITHSTANDING SUBSECTION Y OF THIS SECTION, A CONTRACT DOES NOT  
41 FAIL TO MEET THE REQUIREMENTS OF SUBSECTION Y OF THIS SECTION IF THE  
42 CONTRACT'S FAILURE TO PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED  
43 UNDER SUBSECTION Y OF THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR  
44 COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS  
45 BELIEFS OF THE EMPLOYER, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE

1 CORPORATION, HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION OR  
2 OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE  
3 RELIGIOUS BELIEFS OF THE PURCHASER OF THE COVERAGE. IF AN OBJECTION TRIGGERS  
4 THIS SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE CORPORATION  
5 STATING THE OBJECTION. THE CORPORATION SHALL RETAIN THE AFFIDAVIT FOR THE  
6 DURATION OF THE CONTRACT AND ANY RENEWALS OF THE CONTRACT. THIS SUBSECTION  
7 SHALL NOT EXCLUDE COVERAGE FOR PRESCRIPTION CONTRACEPTIVE METHODS ORDERED BY  
8 A HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY FOR MEDICAL INDICATIONS  
9 OTHER THAN FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION  
10 PURPOSES. A HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION,  
11 HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION, EMPLOYER OR  
12 OTHER ENTITY OFFERING THE PLAN MAY STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT  
13 AND MAY REQUIRE THE SUBSCRIBER TO FIRST PAY FOR THE PRESCRIPTION AND THEN  
14 SUBMIT A CLAIM TO THE HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE  
15 CORPORATION OR HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION  
16 ALONG WITH EVIDENCE THAT THE PRESCRIPTION IS NOT FOR A PURPOSE COVERED BY THE  
17 OBJECTION. A HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR  
18 HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION MAY CHARGE AN  
19 ADMINISTRATIVE FEE FOR HANDLING THESE CLAIMS.

20 AA. SUBSECTION Z OF THIS SECTION DOES NOT AUTHORIZE AN EMPLOYER TO  
21 OBTAIN AN EMPLOYEE'S PROTECTED HEALTH INFORMATION OR TO VIOLATE THE HEALTH  
22 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191; 110 STAT.  
23 1936) OR ANY FEDERAL REGULATIONS ADOPTED PURSUANT TO THAT ACT.

24 BB. SUBSECTION Z OF THIS SECTION SHALL NOT BE CONSTRUED TO RESTRICT OR  
25 LIMIT ANY PROTECTIONS AGAINST EMPLOYMENT DISCRIMINATION THAT ARE PRESCRIBED  
26 IN FEDERAL OR STATE LAW.

27 ~~AA.~~ CC. 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, "child", for purposes of initial  
16 coverage of an adopted child or a child placed for adoption but not for  
17 purposes of termination of coverage of such child, means a person under  
18 eighteen years of age.

19 ~~3. Subsection Z of this section, "religious employer" means an entity  
20 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 primarily serves 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 amended.~~

27 Sec. 2. Section 20-1057.08, Arizona Revised Statutes, is amended to  
28 read:

29 20-1057.08. Prescription contraceptive drugs and devices

30 A. If a health care services organization issues evidence of coverage  
31 that provides coverage for:

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

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

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

4 B. Notwithstanding subsection A OF THIS SECTION, ~~a religious employer~~  
5 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~  
6 ~~may require that the health care services organization provide coverage that~~  
7 ~~excludes all federal food and drug administration approved contraceptive~~  
8 ~~methods. A religious employer shall submit a written affidavit to the health~~  
9 ~~care services organization stating that it is a religious employer. On~~  
10 ~~receipt of the affidavit, the health care services organization shall provide~~  
11 ~~coverage to the religious employer that excludes prescription contraceptive~~  
12 ~~methods.~~ AN EVIDENCE OF COVERAGE DOES NOT FAIL TO MEET THE REQUIREMENTS OF  
13 SUBSECTION A OF THIS SECTION IF THE EVIDENCE OF COVERAGE'S FAILURE TO PROVIDE  
14 COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION A OF THIS  
15 SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR  
16 SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, HEALTH CARE  
17 SERVICES ORGANIZATION OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE  
18 COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE PURCHASER OF THE  
19 COVERAGE. IF AN OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT  
20 SHALL BE FILED WITH THE HEALTH CARE SERVICES ORGANIZATION STATING THE  
21 OBJECTION. The health care services organization shall retain the affidavit  
22 for the duration of the coverage and any renewals of the coverage.

23 ~~C. Before enrollment in the health care plan, every religious employer~~  
24 ~~that invokes this exemption shall provide prospective enrollees written~~  
25 ~~notice that the religious employer refuses to cover all federal food and drug~~  
26 ~~administration approved contraceptive methods for religious reasons.~~

27 ~~D.~~ C. Subsection B OF THIS SECTION does not exclude coverage for  
28 prescription contraceptive methods ordered by a health care provider with  
29 prescriptive authority for medical indications other than ~~to prevent an~~  
30 ~~unintended pregnancy. A health care services organization may require FOR~~  
31 ~~CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. A HEALTH~~  
32 ~~CARE SERVICES ORGANIZATION, EMPLOYER OR OTHER ENTITY OFFERING THE PLAN MAY~~  
33 ~~STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT AND MAY REQUIRE the enrollee to~~  
34 ~~first pay for the prescription and then submit a claim to the health care~~  
35 ~~services organization along with evidence that the prescription is for a~~  
36 ~~noncontraceptive purpose NOT FOR A PURPOSE COVERED BY THE OBJECTION. A~~  
37 ~~health care services organization may charge an administrative fee for~~  
38 ~~handling claims under this subsection.~~

39 ~~E. A religious employer shall not discriminate against an employee who~~  
40 ~~independently chooses to obtain insurance coverage or prescriptions for~~  
41 ~~contraceptives from another source.~~

42 D. SUBSECTIONS B AND C OF THIS SECTION DO NOT AUTHORIZE AN EMPLOYER TO  
43 OBTAIN AN EMPLOYEE'S PROTECTED HEALTH INFORMATION OR TO VIOLATE THE HEALTH  
44 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191; 110 STAT.  
45 1936) OR ANY FEDERAL REGULATIONS ADOPTED PURSUANT TO THAT ACT.

1 E. SUBSECTIONS B AND C OF THIS SECTION SHALL NOT BE CONSTRUED TO  
2 RESTRICT OR LIMIT ANY PROTECTIONS AGAINST EMPLOYMENT DISCRIMINATION THAT ARE  
3 PRESCRIBED IN FEDERAL OR STATE LAW.

4 F. This section does not apply to evidences of coverage issued to  
5 individuals on a nongroup basis.

6 ~~G. For the purposes of this section, "religious employer" means an~~  
7 ~~entity for which all of the following apply:~~

8 ~~1. The entity primarily employs persons who share the religious tenets~~  
9 ~~of the entity.~~

10 ~~2. The entity serves primarily persons who share the religious tenets~~  
11 ~~of the entity.~~

12 ~~3. The entity is a nonprofit organization as described in section~~  
13 ~~6033(a)(2)(A)i or iii of the internal revenue code of 1986, as amended.~~

14 Sec. 3. Section 20-1402, Arizona Revised Statutes, is amended to read:  
15 20-1402. Provisions of group disability policies; definitions

16 A. Each group disability policy shall contain in substance the  
17 following provisions:

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

25 2. A provision that the insurer will furnish to the policyholder, for  
26 delivery to each employee or member of the insured group, an individual  
27 certificate setting forth in summary form a statement of the essential  
28 features of the insurance coverage of the employee or member and to whom  
29 benefits are payable. If dependents or family members are included in the  
30 coverage additional certificates need not be issued for delivery to the  
31 dependents or family members. Any policy, except accidental death and  
32 dismemberment, applied for that provides family coverage, as to such coverage  
33 of family members, shall also provide that the benefits applicable for  
34 children shall be payable with respect to a newly born child of the insured  
35 from the instant of such child's birth, to a child adopted by the insured,  
36 regardless of the age at which the child was adopted, and to a child who has  
37 been placed for adoption with the insured and for whom the application and  
38 approval 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 the necessary care and treatment of medically diagnosed congenital defects  
43 and birth abnormalities. If payment of a specific premium is required to  
44 provide coverage for a child, the policy may require that notification of  
45 birth, adoption or adoption placement of the child and payment of the

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

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

7 4. Each contract shall be so written that the corporation shall pay  
8 benefits:

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

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

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

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

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

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

35 (a) A baseline mammogram for a woman from age thirty-five to  
36 thirty-nine.

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

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

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

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

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

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

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

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

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

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

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

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

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

43 5. Except as described in subsection C of this section, restrict  
44 benefits for any portion of a period within the minimum length of stay in a

1 manner that is less favorable than the benefits provided for any preceding  
2 portion of that stay.

3 C. Nothing in subsection B of this section:

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

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

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

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

19 1. Blood glucose monitors.

20 2. Blood glucose monitors for the legally blind.

21 3. Test strips for glucose monitors and visual reading and urine  
22 testing strips.

23 4. Insulin preparations and glucagon.

24 5. Insulin cartridges.

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

26 7. Injection aids.

27 8. Insulin cartridges for the legally blind.

28 9. Syringes and lancets including automatic lancing devices.

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

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

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

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

41 F. Any contract that provides coverage for prescription drugs shall  
42 not limit or exclude coverage for any prescription drug prescribed for the  
43 treatment of cancer on the basis that the prescription drug has not been  
44 approved by the United States food and drug administration for the treatment  
45 of the specific type of cancer for which the prescription drug has been

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

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

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

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

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

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

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

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

29 1. The acceptable standard medical reference compendia are the  
30 following:

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

33 (b) The national comprehensive cancer network drugs and biologics  
34 compendium.

35 (c) Thomson Micromedex compendium DrugDex.

36 (d) Elsevier gold standard's clinical pharmacology compendium.

37 (e) Other authoritative compendia as identified by the secretary of  
38 the United States department of health and human services.

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 or a registered nurse  
24 practitioner who is licensed pursuant to title 32, chapter 15, that must be  
25 consumed throughout life and without which the person may suffer serious  
26 mental or physical impairment.

27 J. Medical foods eligible for coverage under this section shall be  
28 prescribed or ordered under the supervision of a physician licensed pursuant  
29 to title 32, chapter 13 or 17 or a registered nurse practitioner who is  
30 licensed pursuant to title 32, chapter 15 as medically necessary for the  
31 therapeutic treatment of an inherited metabolic disease.

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

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

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

1 containment measures for contraceptive drugs that are greater than the  
2 deductibles, coinsurance, copayments or other cost containment measures for  
3 other drugs on the same level of the formulary or list.

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

10 M. Notwithstanding subsection L of this section, ~~a religious employer  
11 whose religious tenets prohibit the use of prescribed contraceptive methods  
12 may require that the insurer provide a group disability policy without  
13 coverage for all United States food and drug administration approved  
14 contraceptive methods. A religious employer shall submit a written affidavit  
15 to the insurer stating that it is a religious employer. On receipt of the  
16 affidavit, the insurer shall issue to the religious employer a group  
17 disability policy that excludes coverage of prescription contraceptive  
18 methods.~~ A GROUP DISABILITY POLICY DOES NOT FAIL TO MEET THE REQUIREMENTS OF  
19 SUBSECTION L OF THIS SECTION IF THE POLICY'S FAILURE TO PROVIDE COVERAGE OF  
20 SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION L OF THIS SECTION IS  
21 BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS  
22 CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, INSURER OR OTHER ENTITY  
23 OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS  
24 BELIEFS OF THE PURCHASER OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS  
25 SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE INSURER STATING THE  
26 OBJECTION. The insurer shall retain the affidavit for the duration of the  
27 group disability policy and any renewals of the policy. ~~Before a policy is  
28 issued, every religious employer that invokes this exemption shall provide  
29 prospective insureds written notice that the religious employer refuses to  
30 cover all United States food and drug administration approved contraceptive  
31 methods for religious reasons.~~ This subsection shall not exclude coverage  
32 for prescription contraceptive methods ordered by a health care provider with  
33 prescriptive authority for medical indications other than ~~to prevent an  
34 unintended pregnancy~~ FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR  
35 STERILIZATION PURPOSES. An insurer, EMPLOYER OR OTHER ENTITY OFFERING THE  
36 POLICY may STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT AND MAY require the  
37 insured to first pay for the prescription and then submit a claim to the  
38 insurer along with evidence that the prescription is ~~for a noncontraceptive  
39 purpose~~ NOT FOR A PURPOSE COVERED BY THE OBJECTION. An insurer may charge an  
40 administrative fee for handling these claims. ~~A religious employer shall not  
41 discriminate against an employee who independently chooses to obtain  
42 insurance coverage or prescriptions for contraceptives from another source.~~

43 N. SUBSECTION M OF THIS SECTION DOES NOT AUTHORIZE AN EMPLOYER TO  
44 OBTAIN AN EMPLOYEE'S PROTECTED HEALTH INFORMATION OR TO VIOLATE THE HEALTH

1 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191; 110 STAT.  
2 1936) OR ANY FEDERAL REGULATIONS ADOPTED PURSUANT TO THAT ACT.

3 O. SUBSECTION M OF THIS SECTION SHALL NOT BE CONSTRUED TO RESTRICT OR  
4 LIMIT ANY PROTECTIONS AGAINST EMPLOYMENT DISCRIMINATION THAT ARE PRESCRIBED  
5 IN FEDERAL OR STATE LAW.

6 ~~N.~~ P. For the purposes of:

7 1. This section:

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

11 (b) "Medical foods" means modified low protein foods and metabolic  
12 formula.

13 (c) "Metabolic formula" means foods that are all of the 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 or a registered nurse practitioner who is licensed pursuant to title  
17 32, chapter 15.

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

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

28 (i) Formulated to be consumed or administered enterally under the  
29 supervision of a physician who is licensed pursuant to title 32, chapter 13  
30 or 17 or a registered nurse practitioner who is licensed pursuant to title  
31 32, chapter 15.

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

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

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

41 2. Subsection A of this section, the term "child", for purposes of  
42 initial coverage of an adopted child or a child placed for adoption but not  
43 for purposes of termination of coverage of such child, means a person under  
44 the age of eighteen years.

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

3           ~~(a) The entity primarily employs persons who share the religious~~  
4 ~~tenets of the entity.~~

5           ~~(b) The entity serves primarily persons who share the religious tenets~~  
6 ~~of the entity.~~

7           ~~(c) The entity is a nonprofit organization as described in section~~  
8 ~~6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.~~

9           Sec. 4. Section 20-1404, Arizona Revised Statutes, is amended to read:

10           20-1404. Blanket disability insurance; definitions

11           A. Blanket disability insurance is that form of disability insurance  
12 covering special groups of persons as enumerated in one of the following  
13 paragraphs:

14           1. Under a policy or contract issued to any common carrier, which  
15 shall be deemed the policyholder, covering a group defined as all persons who  
16 may become passengers on such common carrier.

17           2. Under a policy or contract issued to an employer, who shall be  
18 deemed the policyholder, covering all employees or any group of employees  
19 defined by reference to exceptional hazards incident to such employment.  
20 Dependents of the employees and guests of the employer may also be included  
21 where exposed to the same hazards.

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

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

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

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

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

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

40           C. All benefits under any blanket disability policy shall be payable  
41 to the person insured, or to the insured's designated beneficiary or  
42 beneficiaries, or to the insured's estate, except that if the person insured  
43 is a minor, such benefits may be made payable to the insured's parent or  
44 guardian or any other person actually supporting the insured, and except that  
45 the policy may provide that all or any portion of any indemnities provided by

1 any such policy on account of hospital, nursing, medical or surgical  
2 services, at the insurer's option, may be paid directly to the hospital or  
3 person rendering such services, but the policy may not require that the  
4 service be rendered by a particular hospital or person. Payment so made  
5 shall discharge the insurer's obligation with respect to the amount of  
6 insurance so paid.

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

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

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

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

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

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

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

42 G. A blanket disability insurance policy that provides coverage for  
43 the surgical expense of a mastectomy shall also provide coverage incidental  
44 to the patient's covered mastectomy for the expense of reconstructive surgery  
45 of the breast on which the mastectomy was performed, surgery and

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

5 H. 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 I. Any contract that is issued to the insured 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 insured if all the following are true:

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

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

22 3. All preexisting conditions and other limitations have been met by  
23 the insured.

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

27 J. The coverage prescribed by subsection I of this section is excess  
28 to any other coverage the natural mother may have for maternity benefits  
29 except coverage made available to persons pursuant to title 36, chapter 29,  
30 but not including coverage made available to persons defined as eligible  
31 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
32 such other coverage exists the agency, attorney or individual arranging the  
33 adoption shall make arrangements for the insurance to pay those costs that  
34 may be covered under that policy and shall advise the adopting parent in  
35 writing of the existence and extent of the coverage without disclosing any  
36 confidential information such as the identity of the natural parent. The  
37 insured adopting parents shall notify their insurer of the existence and  
38 extent of the other coverage.

39 K. Any contract that provides maternity benefits shall not restrict  
40 benefits for any hospital length of stay in connection with childbirth for  
41 the mother or the newborn child to less than forty-eight hours following a  
42 normal vaginal delivery or ninety-six hours following a cesarean section.  
43 The contract shall not require the provider to obtain authorization from the  
44 insurer for prescribing the minimum length of stay required by this  
45 subsection. The contract may provide that an attending provider in

1 consultation with the mother may discharge the mother or the newborn child  
2 before the expiration of the minimum length of stay required by this  
3 subsection. The insurer shall not:

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

7 2. Provide monetary payments or rebates to mothers to encourage those  
8 mothers to accept less than the minimum protections available pursuant to  
9 this subsection.

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

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

16 5. Except as described in subsection L of this section, restrict  
17 benefits for any portion of a period within the minimum length of stay in a  
18 manner that is less favorable than the benefits provided for any preceding  
19 portion of that stay.

20 L. Nothing in subsection K of this section:

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

23 2. Prevents an insurer from imposing deductibles, coinsurance or other  
24 cost sharing in relation to benefits for hospital lengths of stay in  
25 connection with childbirth for a mother or a newborn child under the  
26 contract, except that any coinsurance or other cost sharing for any portion  
27 of a period within a hospital length of stay required pursuant to subsection  
28 K of this section shall not be greater than the coinsurance or cost sharing  
29 for any preceding portion of that stay.

30 3. Prevents an insurer from negotiating the level and type of  
31 reimbursement with a provider for care provided in accordance with subsection  
32 K of this section.

33 M. Any contract that provides coverage for diabetes shall also provide  
34 coverage for equipment and supplies that are medically necessary and that are  
35 prescribed by a health care provider including:

36 1. Blood glucose monitors.

37 2. Blood glucose monitors for the legally blind.

38 3. Test strips for glucose monitors and visual reading and urine  
39 testing strips.

40 4. Insulin preparations and glucagon.

41 5. Insulin cartridges.

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

43 7. Injection aids.

44 8. Insulin cartridges for the legally blind.

45 9. Syringes and lancets including automatic lancing devices.

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

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

5           12. Any other device, medication, equipment or supply for which  
6 coverage is required under medicare from and after January 1, 1999. The  
7 coverage required in this paragraph is effective six months after the  
8 coverage is required under medicare.

9           N. Nothing in subsection M of this section prohibits a blanket  
10 disability insurer from imposing deductibles, coinsurance or other cost  
11 sharing in relation to benefits for equipment or supplies for the treatment  
12 of diabetes.

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

25           1. Require coverage of any prescription drug used in the treatment of  
26 a type of cancer if the United States food and drug administration has  
27 determined that the prescription drug is contraindicated for that type of  
28 cancer.

29           2. Require coverage for any experimental prescription drug that is not  
30 approved for any indication by the United States food and drug  
31 administration.

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

35           4. Require reimbursement or coverage for any prescription drug that is  
36 not included in the drug formulary or list of covered prescription drugs  
37 specified in the contract.

38           5. Prohibit a contract from limiting or excluding coverage of a  
39 prescription drug, if the decision to limit or exclude coverage of the  
40 prescription drug is not based primarily on the coverage of prescription  
41 drugs required by this section.

42           6. Prohibit the use of deductibles, coinsurance, copayments or other  
43 cost sharing in relation to drug benefits and related medical benefits  
44 offered.

- 1 P. For the purposes of subsection 0 of this section:  
2 1. The acceptable standard medical reference compendia are the  
3 following:  
4 (a) The American hospital formulary service drug information, a  
5 publication of the American society of health system pharmacists.  
6 (b) The national comprehensive cancer network drugs and biologics  
7 compendium.  
8 (c) Thomson Micromedex compendium DrugDex.  
9 (d) Elsevier gold standard's clinical pharmacology compendium.  
10 (e) Other authoritative compendia as identified by the secretary of  
11 the United States department of health and human services.  
12 2. Medical literature may be accepted if all of the following apply:  
13 (a) At least two articles from major peer reviewed professional  
14 medical journals have recognized, based on scientific or medical criteria,  
15 the drug's safety and effectiveness for treatment of the indication for which  
16 the drug has been prescribed.  
17 (b) No article from a major peer reviewed professional medical journal  
18 has concluded, based on scientific or medical criteria, that the drug is  
19 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
20 determined for the treatment of the indication for which the drug has been  
21 prescribed.  
22 (c) The literature meets the uniform requirements for manuscripts  
23 submitted to biomedical journals established by the international committee  
24 of medical journal editors or is published in a journal specified by the  
25 United States department of health and human services as acceptable peer  
26 reviewed medical literature pursuant to section 186(t)(2)(B) of the social  
27 security act (42 United States Code section 1395x(t)(2)(B)).  
28 Q. Any contract that is offered by a blanket disability insurer and  
29 that contains a prescription drug benefit shall provide coverage of medical  
30 foods to treat inherited metabolic disorders as provided by this section.  
31 R. The metabolic disorders triggering medical foods coverage under  
32 this section shall:  
33 1. Be part of the newborn screening program prescribed in section  
34 36-694.  
35 2. Involve amino acid, carbohydrate or fat metabolism.  
36 3. Have medically standard methods of diagnosis, treatment and  
37 monitoring including quantification of metabolites in blood, urine or spinal  
38 fluid or enzyme or DNA confirmation in tissues.  
39 4. Require specially processed or treated medical foods that are  
40 generally available only under the supervision and direction of a physician  
41 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse  
42 practitioner who is licensed pursuant to title 32, chapter 15, that must be  
43 consumed throughout life and without which the person may suffer serious  
44 mental or physical impairment.

1 S. Medical foods eligible for coverage under this section shall be  
2 prescribed or ordered under the supervision of a physician licensed pursuant  
3 to title 32, chapter 13 or 17 or a registered nurse practitioner who is  
4 licensed pursuant to title 32, chapter 15 as medically necessary for the  
5 therapeutic treatment of an inherited metabolic disease.

6 T. An insurer shall cover at least fifty per cent of the cost of  
7 medical foods prescribed to treat inherited metabolic disorders and covered  
8 pursuant to this section. An insurer may limit the maximum annual benefit  
9 for medical foods under this section to five thousand dollars which applies  
10 to the cost of all prescribed modified low protein foods and metabolic  
11 formula.

12 U. Any blanket disability policy that provides coverage for:

13 1. Prescription drugs shall also provide coverage for any prescribed  
14 drug or device that is approved by the United States food and drug  
15 administration for use as a contraceptive. A blanket disability insurer may  
16 use a drug formulary, multitiered drug formulary or list but that formulary  
17 or list shall include oral, implant and injectable contraceptive drugs,  
18 intrauterine devices and prescription barrier methods if the blanket  
19 disability insurer does not impose deductibles, coinsurance, copayments or  
20 other cost containment measures for contraceptive drugs that are greater than  
21 the deductibles, coinsurance, copayments or other cost containment measures  
22 for other drugs on the same level of the formulary or list.

23 2. Outpatient health care services shall also provide coverage for  
24 outpatient contraceptive services. For the purposes of this paragraph,  
25 "outpatient contraceptive services" means consultations, examinations,  
26 procedures and medical services provided on an outpatient basis and related  
27 to the use of approved United States food and drug administration  
28 prescription contraceptive methods to prevent unintended pregnancies.

29 V. Notwithstanding subsection U of this section, ~~a religious employer  
30 whose religious tenets prohibit the use of prescribed contraceptive methods  
31 may require that the insurer provide a blanket disability policy without  
32 coverage for all United States food and drug administration approved  
33 contraceptive methods. A religious employer shall submit a written affidavit  
34 to the insurer stating that it is a religious employer. On receipt of the  
35 affidavit, the insurer shall issue to the religious employer a blanket  
36 disability policy that excludes coverage of prescription contraceptive  
37 methods.~~ A BLANKET DISABILITY POLICY DOES NOT FAIL TO MEET THE REQUIREMENTS  
38 OF SUBSECTION U OF THIS SECTION IF THE POLICY'S FAILURE TO PROVIDE COVERAGE  
39 OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION U OF THIS SECTION IS  
40 BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS  
41 CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, INSURER OR OTHER ENTITY  
42 OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS  
43 BELIEFS OF THE PURCHASER OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS  
44 SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE INSURER STATING THE  
45 OBJECTION. The insurer shall retain the affidavit for the duration of the

1 blanket disability policy and any renewals of the policy. ~~Before a policy is~~  
2 ~~issued, every religious employer that invokes this exemption shall provide~~  
3 ~~prospective insureds written notice that the religious employer refuses to~~  
4 ~~cover all United States food and drug administration approved contraceptive~~  
5 ~~methods for religious reasons.~~ This subsection shall not exclude coverage  
6 for prescription contraceptive methods ordered by a health care provider with  
7 prescriptive authority for medical indications other than ~~to prevent an~~  
8 ~~unintended pregnancy~~ FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR  
9 STERILIZATION PURPOSES. An insurer, EMPLOYER OR OTHER ENTITY OFFERING THE  
10 POLICY may STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT AND MAY require the  
11 insured to first pay for the prescription and then submit a claim to the  
12 insurer along with evidence that the prescription is ~~for a noncontraceptive~~  
13 ~~purpose~~ NOT FOR A PURPOSE COVERED BY THE OBJECTION. An insurer may charge an  
14 administrative fee for handling these claims under this subsection.  
15 ~~A religious employer shall not discriminate against an employee who~~  
16 ~~independently chooses to obtain insurance coverage or prescriptions for~~  
17 ~~contraceptives from another source.~~

18 W. SUBSECTION V OF THIS SECTION DOES NOT AUTHORIZE AN EMPLOYER TO  
19 OBTAIN AN EMPLOYEE'S PROTECTED HEALTH INFORMATION OR TO VIOLATE THE HEALTH  
20 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191; 110 STAT.  
21 1936) OR ANY FEDERAL REGULATIONS ADOPTED PURSUANT TO THAT ACT.

22 X. SUBSECTION V OF THIS SECTION SHALL NOT BE CONSTRUED TO RESTRICT OR  
23 LIMIT ANY PROTECTIONS AGAINST EMPLOYMENT DISCRIMINATION THAT ARE PRESCRIBED  
24 IN FEDERAL OR STATE LAW.

25 ~~W.~~ Y. For the purposes of:

26 1. This section:

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

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

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

33 (i) Formulated to be consumed or administered enterally under the  
34 supervision of a physician who is licensed pursuant to title 32, chapter 13  
35 or 17 or a registered nurse practitioner who is licensed pursuant to title  
36 32, chapter 15.

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 or a registered nurse practitioner who is licensed pursuant to title  
6 32, chapter 15.

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

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

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

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

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

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

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

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

28 Sec. 5. Section 20-2329, Arizona Revised Statutes, is amended to read:  
29 20-2329. Prescription contraceptive drugs and devices

30 A. An accountable health plan that provides a health benefits plan  
31 that provides coverage for:

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

42 2. Outpatient health care services shall also provide coverage for  
43 outpatient contraceptive services. For the purposes of this paragraph,  
44 "outpatient contraceptive services" means consultations, examinations,  
45 procedures and medical services provided on an outpatient basis and related

1 to the use of United States food and drug prescription contraceptive methods  
2 to prevent unintended pregnancies.

3 B. Notwithstanding subsection A OF THIS SECTION, ~~a religious employer~~  
4 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~  
5 ~~may require that the accountable health plan provide a health benefits plan~~  
6 ~~without coverage for all federal food and drug administration approved~~  
7 ~~contraceptive methods. A religious employer shall submit a written affidavit~~  
8 ~~to the accountable health plan stating that it is a religious employer. On~~  
9 ~~receipt of the affidavit, the accountable health plan shall issue to the~~  
10 ~~religious employer a health benefits plan that excludes coverage of~~  
11 ~~prescription contraceptive methods. AN ACCOUNTABLE HEALTH PLAN DOES NOT FAIL~~  
12 ~~TO MEET THE REQUIREMENTS OF SUBSECTION A OF THIS SECTION IF THE PLAN'S~~  
13 ~~FAILURE TO PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER~~  
14 ~~SUBSECTION A OF THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF~~  
15 ~~THE SPECIFIC ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE~~  
16 ~~EMPLOYER, ACCOUNTABLE HEALTH PLAN OR OTHER ENTITY OFFERING THE PLAN OR IS~~  
17 ~~BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE PURCHASER OF~~  
18 ~~THE COVERAGE. IF AN OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT~~  
19 ~~SHALL BE FILED WITH THE ACCOUNTABLE HEALTH PLAN STATING THE OBJECTION. The~~  
20 ~~accountable health plan shall retain the affidavit for the duration of the~~  
21 ~~health benefits plan and any renewals of the plan.~~

22 ~~C. Before enrollment in the plan, every religious employer that~~  
23 ~~invokes this exemption shall provide prospective enrollees written notice~~  
24 ~~that the religious employer refuses to cover all federal food and drug~~  
25 ~~administration approved contraceptive methods for religious reasons.~~

26 ~~D.~~ C. Subsection B OF THIS SECTION shall not exclude coverage for  
27 prescription contraceptive methods ordered by a health care provider with  
28 prescriptive authority for medical indications other than ~~to prevent an~~  
29 ~~unintended pregnancy FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR~~  
30 ~~STERILIZATION PURPOSES. An accountable health plan, EMPLOYER OR OTHER ENTITY~~  
31 ~~OFFERING THE PLAN may STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT AND MAY~~  
32 ~~require the enrollee to first pay for the prescription and then submit a~~  
33 ~~claim to the accountable health plan along with evidence that the~~  
34 ~~prescription is for a noncontraceptive purpose NOT FOR A PURPOSE COVERED BY~~  
35 ~~THE OBJECTION. An accountable health plan may charge an administrative fee~~  
36 ~~for handling claims under this subsection.~~

37 ~~E. A religious employer shall not discriminate against an employee who~~  
38 ~~independently chooses to obtain insurance coverage or prescriptions for~~  
39 ~~contraceptives from another source.~~

40 ~~F. For the purposes of this section, "religious employer" means an~~  
41 ~~entity for which all of the following apply:~~

42 ~~1. The entity primarily employs persons who share the religious tenets~~  
43 ~~of the entity.~~

44 ~~2. The entity serves primarily persons who share the religious tenets~~  
45 ~~of the entity.~~

1           ~~3. 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 amended.~~

3           D. SUBSECTIONS B AND C OF THIS SECTION DO NOT AUTHORIZE AN EMPLOYER TO  
4 OBTAIN AN EMPLOYEE'S PROTECTED HEALTH INFORMATION OR TO VIOLATE THE HEALTH  
5 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191; 110 STAT.  
6 1936) OR ANY FEDERAL REGULATIONS ADOPTED PURSUANT TO THAT ACT.

7           E. SUBSECTIONS B AND C OF THIS SECTION SHALL NOT BE CONSTRUED TO  
8 RESTRICT OR LIMIT ANY PROTECTIONS AGAINST EMPLOYMENT DISCRIMINATION THAT ARE  
9 PRESCRIBED IN FEDERAL OR STATE LAW.

10           Sec. 6. Applicability

11           This act applies to contracts, policies and evidences of coverage  
12 issued or renewed from and after the effective date of this act.