

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2625

(Reference to printed bill)

1 Strike everything after the enacting clause and insert:

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.

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

4           D. Each contract for dental or optometric services shall be so written  
5 that the corporation shall pay benefits for contracted dental or optometric  
6 services provided by dentists or optometrists.

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

25           F. Each contract that is delivered or issued for delivery in this  
26 state after December 25, 1977 and that provides that coverage of a dependent  
27 child shall terminate on attainment of the limiting age for dependent  
28 children specified in the contract shall also provide in substance that  
29 attainment of such limiting age shall not operate to terminate the coverage  
30 of such child while the child is and continues to be both incapable of  
31 self-sustaining employment by reason of intellectual disability or physical  
32 handicap and chiefly dependent on the subscriber for support and maintenance.

1 Proof of such incapacity and dependency shall be furnished to the corporation  
2 by the subscriber within thirty-one days of the child's attainment of the  
3 limiting age and subsequently as may be required by the corporation, but not  
4 more frequently than annually after the two-year period following the child's  
5 attainment of the limiting age.

6 G. No corporation may cancel or refuse to renew any subscriber's  
7 contract without giving notice of such cancellation or nonrenewal to the  
8 subscriber under such contract. A notice by the corporation to the  
9 subscriber of cancellation or nonrenewal of a subscription contract shall be  
10 mailed to the named subscriber at least forty-five days before the effective  
11 date of such cancellation or nonrenewal. The notice shall include or be  
12 accompanied by a statement in writing of the reasons for such action by the  
13 corporation. Failure of the corporation to comply with this subsection shall  
14 invalidate any cancellation or nonrenewal except a cancellation or nonrenewal  
15 for nonpayment of premium.

16 H. A contract that provides coverage for surgical services for a  
17 mastectomy shall also provide coverage incidental to the patient's covered  
18 mastectomy for surgical services for reconstruction of the breast on which  
19 the mastectomy was performed, surgery and reconstruction of the other breast  
20 to produce a symmetrical appearance, prostheses, treatment of physical  
21 complications for all stages of the mastectomy, including lymphedemas, and at  
22 least two external postoperative prostheses subject to all of the terms and  
23 conditions of the policy.

24 I. A contract that provides coverage for surgical services for a  
25 mastectomy shall also provide coverage for mammography screening performed on  
26 dedicated equipment for diagnostic purposes on referral by a patient's  
27 physician, subject to all of the terms and conditions of the policy and  
28 according to the following guidelines:

29 1. A baseline mammogram for a woman from age thirty-five to  
30 thirty-nine.

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

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

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

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

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

11          3. All preexisting conditions and other limitations have been met by  
12 the insured.

13          4. The insured has notified the insurer of the insured's acceptability  
14 to adopt children pursuant to section 8-105, within sixty days after such  
15 approval or within sixty days after a change in insurance policies, plans or  
16 companies.

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

29          L. The director may disapprove any contract if the benefits provided  
30 in the form of such contract are unreasonable in relation to the premium  
31 charged.

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

- 4           1. Conditions of eligibility.
- 5           2. Coverage of dependents.
- 6           3. Preexisting conditions.
- 7           4. Termination of insurance.
- 8           5. Probationary periods.
- 9           6. Limitations.
- 10          7. Exceptions.
- 11          8. Reductions.
- 12          9. Elimination periods.
- 13          10. Requirements for replacement.
- 14          11. Any other condition of subscription contracts.

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

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

28           2. Provide monetary payments or rebates to mothers to encourage those  
29 mothers to accept less than the minimum protections available pursuant to  
30 this subsection.

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

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

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

11           O. Nothing in subsection N of this section:

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

14           2. Prevents a corporation from imposing deductibles, coinsurance or  
15 other cost sharing in relation to benefits for hospital lengths of stay in  
16 connection with childbirth for a mother or a newborn child under the  
17 contract, except that any coinsurance or other cost sharing for any portion  
18 of a period within a hospital length of stay required pursuant to subsection  
19 N of this section shall not be greater than the coinsurance or cost sharing  
20 for any preceding portion of that stay.

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

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

27           1. Blood glucose monitors.

28           2. Blood glucose monitors for the legally blind.

29           3. Test strips for glucose monitors and visual reading and urine  
30 testing strips.

31           4. Insulin preparations and glucagon.

32           5. Insulin cartridges.

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

2           7. Injection aids.

3           8. Insulin cartridges for the legally blind.

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

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

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

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

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

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

30           1. Require coverage of any prescription drug used in the treatment of  
31 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. Notwithstanding section 20-841.05, require reimbursement or  
10 coverage for any prescription drug that is not included in the drug formulary  
11 or list of covered prescription drugs specified in the contract.

12 5. Notwithstanding section 20-841.05, prohibit a contract from  
13 limiting or excluding coverage of a prescription drug, if the decision to  
14 limit or exclude coverage of the prescription drug is not based primarily on  
15 the coverage of prescription 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 S. For the purposes of subsection R of this section:

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

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

24 (b) The national comprehensive cancer network drugs and biologics  
25 compendium.

26 (c) Thomson Micromedex compendium DrugDex.

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

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

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

31 (a) At least two articles from major peer reviewed professional  
32 medical journals have recognized, based on scientific or medical criteria,

1 the drug's safety and effectiveness for treatment of the indication for which  
2 the drug has been prescribed.

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

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

14 T. A corporation shall not issue or deliver any advertising matter or  
15 sales material to any person in this state until the corporation files the  
16 advertising matter or sales material with the director. This subsection does  
17 not require a corporation to have the prior approval of the director to issue  
18 or deliver the advertising matter or sales material. If the director finds  
19 that the advertising matter or sales material, in whole or in part, is false,  
20 deceptive or misleading, the director may issue an order disapproving the  
21 advertising matter or sales material, directing the corporation to cease and  
22 desist from issuing, circulating, displaying or using the advertising matter  
23 or sales material within a period of time specified by the director but not  
24 less than ten days and imposing any penalties prescribed in this title. At  
25 least five days before issuing an order pursuant to this subsection, the  
26 director shall provide the corporation with a written notice of the basis of  
27 the order to provide the corporation with an opportunity to cure the alleged  
28 deficiency in the advertising matter or sales material within a single five  
29 day period for the particular advertising matter or sales material at issue.  
30 The corporation may appeal the director's order pursuant to title 41,  
31 chapter 6, article 10. Except as otherwise provided in this subsection, a  
32 corporation may obtain a stay of the effectiveness of the order as prescribed

1 in section 20-162. If the director certifies in the order and provides a  
2 detailed explanation of the reasons in support of the certification that  
3 continued use of the advertising matter or sales material poses a threat to  
4 the health, safety or welfare of the public, the order may be entered  
5 immediately without opportunity for cure and the effectiveness of the order  
6 is not stayed pending the hearing on the notice of appeal but the hearing  
7 shall be promptly instituted and determined.

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

12 V. The metabolic disorders triggering medical foods coverage under  
13 this section shall:

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

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

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

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

26 W. 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 X. A hospital service corporation or medical service corporation shall  
31 cover at least fifty per cent of the cost of medical foods prescribed to  
32 treat inherited metabolic disorders and covered pursuant to this section. A

1 hospital service corporation or medical service corporation may limit the  
2 maximum annual benefit for medical foods under this section to five thousand  
3 dollars, which applies to the cost of all prescribed modified low protein  
4 foods and metabolic formula.

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

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

18 2. If the contract provides coverage for outpatient health care  
19 services, the contract shall provide coverage for outpatient contraceptive  
20 services. For the purposes of this paragraph, "outpatient contraceptive  
21 services" means consultations, examinations, procedures and medical services  
22 provided on an outpatient basis and related to the use of approved United  
23 States food and drug administration prescription contraceptive methods to  
24 prevent unintended pregnancies.

25 3. This subsection does not apply to contracts issued to individuals  
26 on a nongroup basis.

27 ~~Z. Notwithstanding subsection Y of this section, a religious employer  
28 whose religious tenets prohibit the use of prescribed contraceptive methods  
29 may require that the corporation provide a contract without coverage for all  
30 United States food and drug administration approved contraceptive methods. A  
31 religious employer shall submit a written affidavit to the corporation  
32 stating that it is a religious employer. On receipt of the affidavit, the~~

~~corporation shall issue to the religious employer a contract that excludes coverage of prescription contraceptive methods. The corporation shall retain the affidavit for the duration of the contract and any renewals of the contract. Before enrollment in the plan, every religious employer that invokes this exemption shall provide prospective subscribers written notice that the religious employer refuses to cover all United States food and drug administration approved contraceptive methods for religious reasons. This subsection shall not exclude coverage for prescription contraceptive methods ordered by a health care provider with prescriptive authority for medical indications other than to prevent an unintended pregnancy. A corporation may require the subscriber to first pay for the prescription and then submit a claim to the corporation along with evidence that the prescription is for a noncontraceptive purpose. A corporation may charge an administrative fee for handling these claims. A religious employer shall not discriminate against an employee who independently chooses to obtain insurance coverage or prescriptions for contraceptives from another source.~~

Z. A CONTRACT SHALL NOT BE CONSIDERED TO HAVE FAILED THE REQUIREMENTS OF SUBSECTION Y OF THIS SECTION IF THE CONTRACT'S FAILURE TO PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION Y OF THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, SPONSOR, ISSUER, CORPORATION OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE CORPORATION STATING THE OBJECTION. THE CORPORATION SHALL RETAIN THE AFFIDAVIT FOR THE DURATION OF THE CONTRACT AND ANY RENEWALS OF THE CONTRACT. THIS SUBSECTION SHALL NOT EXCLUDE COVERAGE FOR PRESCRIPTION CONTRACEPTIVE METHODS ORDERED BY A HEALTH CARE PROVIDER PRESCRIPTIVE AUTHORITY FOR MEDICAL INDICATIONS OTHER THAN FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. A CORPORATION, EMPLOYER, SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE PLAN MAY STATE RELIGIOUS BELIEFS OR MORAL CONVICTIONS IN ITS AFFIDAVIT THAT REQUIRE THE SUBSCRIBER TO FIRST

1 PAY FOR THE PRESCRIPTION AND THEN SUBMIT A CLAIM TO THE CORPORATION ALONG  
2 WITH EVIDENCE THAT THE PRESCRIPTION IS NOT IN WHOLE OR IN PART FOR A PURPOSE  
3 COVERED BY THE OBJECTION. A CORPORATION MAY CHARGE AN ADMINISTRATIVE FEE FOR  
4 HANDLING THESE CLAIMS.

5 AA. For the purposes of:

6 1. This section:

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

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

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

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

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

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

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

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

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

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

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 2. Subsection E of this section, "child", for purposes of initial  
8 coverage of an adopted child or a child placed for adoption but not for  
9 purposes of termination of coverage of such child, means a person under  
10 eighteen years of age.

11 ~~3. Subsection Z of this section, "religious employer" means an entity  
12 for which all of the following apply:~~

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

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

17 ~~(c) The entity is a nonprofit organization as described in section  
18 6033(a)(2)(A) (i) or (iii) of the internal revenue code of 1986, as amended.~~

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

21 20-1057.08. Prescription contraceptive drugs and devices

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

24 1. Prescription drugs, the evidence of coverage shall provide coverage  
25 for any prescribed drug or device that is approved by the United States food  
26 and drug administration for use as a contraceptive. A health care services  
27 organization may use a drug formulary, multitiered drug formulary or list but  
28 that formulary or list shall include oral, implant and injectable  
29 contraceptive drugs, intrauterine devices and prescription barrier methods if  
30 the health care services organization does not impose deductibles,  
31 coinsurance, copayments or other cost containment measures for contraceptive  
32 drugs that are greater than the deductibles, coinsurance, copayments or other

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

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

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

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

1           ~~D.~~ C. Subsection B OF THIS SECTION does not exclude coverage for  
2 prescription contraceptive methods ordered by a health care provider with  
3 prescriptive authority for medical indications other than ~~to prevent an~~  
4 ~~unintended pregnancy. A health care services organization may require FOR~~  
5 ~~CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. A HEALTH~~  
6 ~~CARE SERVICES ORGANIZATION, EMPLOYER, SPONSOR, ISSUER OR OTHER ENTITY~~  
7 ~~OFFERING THE PLAN MAY STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT THAT REQUIRE~~  
8 the enrollee to first pay for the prescription and then submit a claim to the  
9 health care services organization along with evidence that the prescription  
10 is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART FOR A PURPOSE  
11 COVERED BY THE OBJECTION. A health care services organization may charge an  
12 administrative fee for handling claims under this subsection.

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

16           ~~F.~~ D. This section does not apply to evidences of coverage issued to  
17 individuals on a nongroup basis.

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

20           ~~1. The entity primarily employs persons who share the religious tenets~~  
21 ~~of the entity.~~

22           ~~2. The entity serves primarily persons who share the religious tenets~~  
23 ~~of the entity.~~

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

26           Sec. 3. Section 20-1402, Arizona Revised Statutes, is amended to read:  
27           20-1402. Provisions of group disability policies; definitions

28           A. Each group disability policy shall contain in substance the  
29 following provisions:

30           1. A provision that, in the absence of fraud, all statements made by  
31 the policyholder or by any insured person shall be deemed representations and  
32 not warranties, and that no statement made for the purpose of effecting

1 insurance shall avoid such insurance or reduce benefits unless contained in a  
2 written instrument signed by the policyholder or the insured person, a copy  
3 of which has been furnished to the policyholder or to the person or  
4 beneficiary.

5 2. A provision that the insurer will furnish to the policyholder, for  
6 delivery to each employee or member of the insured group, an individual  
7 certificate setting forth in summary form a statement of the essential  
8 features of the insurance coverage of the employee or member and to whom  
9 benefits are payable. If dependents or family members are included in the  
10 coverage additional certificates need not be issued for delivery to the  
11 dependents or family members. Any policy, except accidental death and  
12 dismemberment, applied for that provides family coverage, as to such coverage  
13 of family members, shall also provide that the benefits applicable for  
14 children shall be payable with respect to a newly born child of the insured  
15 from the instant of such child's birth, to a child adopted by the insured,  
16 regardless of the age at which the child was adopted, and to a child who has  
17 been placed for adoption with the insured and for whom the application and  
18 approval procedures for adoption pursuant to section 8-105 or 8-108 have been  
19 completed to the same extent that such coverage applies to other members of  
20 the family. The coverage for newly born or adopted children or children  
21 placed for adoption shall include coverage of injury or sickness including  
22 the necessary care and treatment of medically diagnosed congenital defects  
23 and birth abnormalities. If payment of a specific premium is required to  
24 provide coverage for a child, the policy may require that notification of  
25 birth, adoption or adoption placement of the child and payment of the  
26 required premium must be furnished to the insurer within thirty-one days  
27 after the date of birth, adoption or adoption placement in order to have the  
28 coverage continue beyond such thirty-one day period.

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

1           4. Each contract shall be so written that the corporation shall pay  
2 benefits:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29           B. Any policy that provides maternity benefits shall not restrict  
30 benefits for any hospital length of stay in connection with childbirth for  
31 the mother or the newborn child to less than forty-eight hours following a  
32 normal vaginal delivery or ninety-six hours following a cesarean section.

1 The policy shall not require the provider to obtain authorization from the  
2 insurer for prescribing the minimum length of stay required by this  
3 subsection. The policy 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 insurer 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 policy  
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 policy 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 policy in a  
18 manner that is inconsistent with this subsection.

19 5. Except as described in subsection C 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 C. Nothing in subsection B 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 an insurer from imposing deductibles, coinsurance or other  
27 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 policy,  
29 except that any coinsurance or other cost sharing for any portion of a period  
30 within a hospital length of stay required pursuant to subsection B of this  
31 section shall not be greater than the coinsurance or cost sharing for any  
32 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  
3 subsection 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 prohibits a group  
26 disability insurer from imposing deductibles, coinsurance or other cost  
27 sharing in relation to benefits for equipment or supplies for the treatment  
28 of diabetes.

29           F. Any contract that provides coverage for prescription drugs shall  
30 not limit or exclude coverage for any prescription drug prescribed for the  
31 treatment of cancer on the basis that the prescription drug has not been  
32 approved by the United States food and drug administration for the treatment

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

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

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

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

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

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

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

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

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

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

3 (b) The national comprehensive cancer network drugs and biologics  
4 compendium.

5 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

28 I. The metabolic disorders triggering medical foods coverage under  
29 this section shall:

30 1. Be part of the newborn screening program prescribed in section  
31 36-694.

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

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

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

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

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

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

22           1. Prescription drugs shall also provide coverage for any prescribed  
23 drug or device that is approved by the United States food and drug  
24 administration for use as a contraceptive. A group disability insurer may  
25 use a drug formulary, multitiered drug formulary or list but that formulary  
26 or list shall include oral, implant and injectable contraceptive drugs,  
27 intrauterine devices and prescription barrier methods if the group disability  
28 insurer does not impose deductibles, coinsurance, copayments or other cost  
29 containment measures for contraceptive drugs that are greater than the  
30 deductibles, coinsurance, copayments or other cost containment measures for  
31 other drugs on the same level of the formulary or list.

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

7           M. Notwithstanding subsection L of this section, ~~a religious employer~~  
8 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~  
9 ~~may require that the insurer provide a group disability policy without~~  
10 ~~coverage for all United States food and drug administration approved~~  
11 ~~contraceptive methods. A religious employer shall submit a written affidavit~~  
12 ~~to the insurer stating that it is a religious employer. On receipt of the~~  
13 ~~affidavit, the insurer shall issue to the religious employer a group~~  
14 ~~disability policy that excludes coverage of prescription contraceptive~~  
15 ~~methods.~~ A GROUP DISABILITY POLICY SHALL NOT BE CONSIDERED TO HAVE FAILED  
16 THE REQUIREMENTS OF SUBSECTION L OF THIS SECTION IF THE POLICY'S FAILURE TO  
17 PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION L OF  
18 THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC  
19 ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER,  
20 SPONSOR, ISSUER, INSURER OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE  
21 COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE PURCHASER OR BENEFICIARY  
22 OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN  
23 AFFIDAVIT SHALL BE FILED WITH THE INSURER STATING THE OBJECTION. The insurer  
24 shall retain the affidavit for the duration of the group disability policy  
25 and any renewals of the policy. ~~Before a policy is issued, every religious~~  
26 ~~employer that invokes this exemption shall provide prospective insureds~~  
27 ~~written notice that the religious employer refuses to cover all United States~~  
28 ~~food and drug administration approved contraceptive methods for religious~~  
29 ~~reasons.~~ This subsection shall not exclude coverage for prescription  
30 contraceptive methods ordered by a health care provider with prescriptive  
31 authority for medical indications other than ~~to prevent an unintended~~  
32 ~~pregnancy~~ FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION

1           PURPOSES. An insurer, EMPLOYER, SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE  
2           POLICY may STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT THAT require the insured  
3           to first pay for the prescription and then submit a claim to the insurer  
4           along with evidence that the prescription is ~~for a noncontraceptive purpose~~  
5           NOT IN WHOLE OR IN PART FOR A PURPOSE COVERED BY THE OBJECTION. An insurer  
6           may charge an administrative fee for handling these claims. ~~A religious~~  
7           ~~employer shall not discriminate against an employee who independently chooses~~  
8           ~~to obtain insurance coverage or prescriptions for contraceptives from another~~  
9           ~~source.~~

10           N. For the purposes of:

11           1. This section:

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

15           (b) "Medical foods" means modified low protein foods and metabolic  
16           formula.

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

18           (i) Formulated to be consumed or administered enterally under the  
19           supervision of a physician who is licensed pursuant to title 32, chapter 13  
20           or 17 or a registered nurse practitioner who is licensed pursuant to title  
21           32, chapter 15.

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

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

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

30           (d) "Modified low protein foods" means foods that are all of the  
31           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 or a registered nurse practitioner who is licensed pursuant to title  
4 32, chapter 15.

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

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

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

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

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

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

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

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

26 Sec. 4. Section 20-1404, Arizona Revised Statutes, is amended to read:  
27 20-1404. Blanket disability insurance; definitions

28 A. Blanket disability insurance is that form of disability insurance  
29 covering special groups of persons as enumerated in one of the following  
30 paragraphs:

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

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

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

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

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

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

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

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

27           C. All benefits under any blanket disability policy shall be payable  
28 to the person insured, or to the insured's designated beneficiary or  
29 beneficiaries, or to the insured's estate, except that if the person insured  
30 is a minor, such benefits may be made payable to the insured's parent or  
31 guardian or any other person actually supporting the insured, and except that  
32 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.

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

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

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

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

19           H. A contract that provides coverage for surgical services for a  
20 mastectomy shall also provide coverage for mammography screening performed on  
21 dedicated equipment for diagnostic purposes on referral by a patient's  
22 physician, subject to all of the terms and conditions of the policy and  
23 according to the following guidelines:

24           1. A baseline mammogram for a woman from age thirty-five to  
25 thirty-nine.

26           2. A mammogram for a woman from age forty to forty-nine every two  
27 years or more frequently based on the recommendation of the woman's  
28 physician.

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

30           I. Any contract that is issued to the insured and that provides  
31 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 1. The child is adopted within one year of birth.  
4 2. The insured is legally obligated to pay the costs of birth.  
5 3. All preexisting conditions and other limitations have been met by  
6 the insured.

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

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

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

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

4           2. Provide monetary payments or rebates to mothers to encourage those  
5 mothers to accept less than the minimum protections available pursuant to  
6 this subsection.

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

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

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

17          L. Nothing in subsection K of this section:

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

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

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

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

- 1           1. Blood glucose monitors.
- 2           2. Blood glucose monitors for the legally blind.
- 3           3. Test strips for glucose monitors and visual reading and urine
- 4 testing strips.
- 5           4. Insulin preparations and glucagon.
- 6           5. Insulin cartridges.
- 7           6. Drawing up devices and monitors for the visually impaired.
- 8           7. Injection aids.
- 9           8. Insulin cartridges for the legally blind.
- 10          9. Syringes and lancets including automatic lancing devices.
- 11          10. Prescribed oral agents for controlling blood sugar that are
- 12 included on the plan formulary.
- 13          11. To the extent coverage is required under medicare, podiatric
- 14 appliances for prevention of complications associated with diabetes.
- 15          12. Any other device, medication, equipment or supply for which
- 16 coverage is required under medicare from and after January 1, 1999. The
- 17 coverage required in this paragraph is effective six months after the
- 18 coverage is required under medicare.
- 19          N. Nothing in subsection M of this section prohibits a blanket
- 20 disability insurer from imposing deductibles, coinsurance or other cost
- 21 sharing in relation to benefits for equipment or supplies for the treatment
- 22 of diabetes.
- 23          O. Any contract that provides coverage for prescription drugs shall
- 24 not limit or exclude coverage for any prescription drug prescribed for the
- 25 treatment of cancer on the basis that the prescription drug has not been
- 26 approved by the United States food and drug administration for the treatment
- 27 of the specific type of cancer for which the prescription drug has been
- 28 prescribed, if the prescription drug has been recognized as safe and
- 29 effective for treatment of that specific type of cancer in one or more of the
- 30 standard medical reference compendia prescribed in subsection P of this
- 31 section or medical literature that meets the criteria prescribed in
- 32 subsection P of this section. The coverage required under this subsection

1 includes covered medically necessary services associated with the  
2 administration of the prescription drug. This subsection does not:

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

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

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

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

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

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

23 P. For the purposes of subsection 0 of this section:

24 1. The acceptable standard medical reference compendia are the  
25 following:

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

28 (b) The national comprehensive cancer network drugs and biologics  
29 compendium.

30 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

19 Q. Any contract that is offered by a blanket disability insurer and  
20 that contains a prescription drug benefit shall provide coverage of medical  
21 foods to treat inherited metabolic disorders as provided by this section.

22 R. The metabolic disorders triggering medical foods coverage under  
23 this section shall:

24 1. Be part of the newborn screening program prescribed in section  
25 36-694.

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

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

30 4. Require specially processed or treated medical foods that are  
31 generally available only under the supervision and direction of a physician  
32 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse

1 practitioner who is licensed pursuant to title 32, chapter 15, that must be  
2 consumed throughout life and without which the person may suffer serious  
3 mental or physical impairment.

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

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

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

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

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

1           V. Notwithstanding subsection U of this section, ~~a religious employer~~  
2 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~  
3 ~~may require that the insurer provide a blanket disability policy without~~  
4 ~~coverage for all United States food and drug administration approved~~  
5 ~~contraceptive methods. A religious employer shall submit a written affidavit~~  
6 ~~to the insurer stating that it is a religious employer. On receipt of the~~  
7 ~~affidavit, the insurer shall issue to the religious employer a blanket~~  
8 ~~disability policy that excludes coverage of prescription contraceptive~~  
9 ~~methods.~~ A BLANKET DISABILITY POLICY SHALL NOT BE CONSIDERED TO HAVE FAILED  
10 THE REQUIREMENTS OF SUBSECTION U OF THIS SECTION IF THE POLICY'S FAILURE TO  
11 PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION U OF  
12 THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC  
13 ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER,  
14 SPONSOR, ISSUER, INSURER OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE  
15 COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE PURCHASER OR BENEFICIARY  
16 OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN  
17 AFFIDAVIT SHALL BE FILED WITH THE INSURER STATING THE OBJECTION. The insurer  
18 shall retain the affidavit for the duration of the blanket disability policy  
19 and any renewals of the policy. ~~Before a policy is issued, every religious~~  
20 ~~employer that invokes this exemption shall provide prospective insureds~~  
21 ~~written notice that the religious employer refuses to cover all United States~~  
22 ~~food and drug administration approved contraceptive methods for religious~~  
23 ~~reasons.~~ This subsection shall not exclude coverage for prescription  
24 contraceptive methods ordered by a health care provider with prescriptive  
25 authority for medical indications other than ~~to prevent an unintended~~  
26 ~~pregnancy~~ FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION  
27 PURPOSES. An insurer, EMPLOYER, SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE  
28 POLICY may STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT THAT require the insured  
29 to first pay for the prescription and then submit a claim to the insurer  
30 along with evidence that the prescription is ~~for a noncontraceptive purpose~~  
31 NOT IN WHOLE OR IN PART FOR A PURPOSE COVERED BY THE OBJECTION. An insurer  
32 may charge an administrative fee for handling these claims under this

1 subsection. ~~A religious employer shall not discriminate against an employee~~  
2 ~~who independently chooses to obtain insurance coverage or prescriptions for~~  
3 ~~contraceptives from another source.~~

4 W. For the purposes of:

5 1. This section:

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

9 (b) "Medical foods" means modified low protein foods and metabolic  
10 formula.

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

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

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

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

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

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

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

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

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

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

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

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

17 ~~(c) The entity is a nonprofit organization as described in section  
18 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.~~

19 Sec. 5. Section 20-2329, Arizona Revised Statutes, is amended to read:

20 20-2329. Prescription contraceptive drugs and devices

21 A. An accountable health plan that provides a health benefits plan  
22 that provides coverage for:

23 1. Prescription drugs shall also provide coverage for any prescribed  
24 drug or device that is approved by the United States food and drug  
25 administration for use as a contraceptive. An accountable health plan may  
26 use a drug formulary, multitiered drug formulary or list but that formulary  
27 or list shall include oral, implant and injectable contraceptive drugs,  
28 intrauterine devices and prescription barrier methods if the accountable  
29 health plan does not impose deductibles, coinsurance, copayments or other  
30 cost containment measures for contraceptive drugs that are greater than the  
31 deductibles, coinsurance, copayments or other cost containment measures for  
32 other drugs on the same level of the formulary or list.

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

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

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

31           ~~D.~~ C. Subsection B OF THIS SECTION shall not exclude coverage for  
32 prescription contraceptive methods ordered by a health care provider with

1 prescriptive authority for medical indications other than ~~to prevent an~~  
2 ~~unintended pregnancy~~ FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR  
3 STERILIZATION PURPOSES. An accountable health plan, EMPLOYER, SPONSOR,  
4 ISSUER OR OTHER ENTITY OFFERING THE PLAN may STATE RELIGIOUS BELIEFS IN ITS  
5 AFFIDAVIT THAT require the enrollee to first pay for the prescription and  
6 then submit a claim to the accountable health plan along with evidence that  
7 the prescription is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART  
8 FOR A PURPOSE COVERED BY THE OBJECTION. An accountable health plan may charge  
9 an administrative fee for handling claims under this subsection.

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

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

15 ~~1. The entity primarily employs persons who share the religious tenets~~  
16 ~~of the entity.~~

17 ~~2. The entity serves primarily persons who share the religious tenets~~  
18 ~~of the entity.~~

19 ~~3. The entity is a nonprofit organization as described in section~~  
20 ~~6033(a)(2)(A)i or iii of the internal revenue code of 1986, as amended."~~

21 Amend title to conform

EDWIN W. FARNSWORTH

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