

REFERENCE TITLE: **contraception; cost sharing prohibition**

State of Arizona  
House of Representatives  
Fifty-third Legislature  
Second Regular Session  
2018

## **HB 2218**

Introduced by  
Representatives Salman: Alston, Andrade, Blanc, Bolding, Cardenas,  
Chávez, Clark, Espinoza, Fernandez, Friese, Gonzales, Hernandez, Powers  
Hannley, Rios, Saldate, Senators Mendez, Peshlakai

**AN ACT**

**AMENDING SECTIONS 20-826 AND 20-1057.08, ARIZONA REVISED STATUTES;  
AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY  
ADDING SECTION 20-1376.10; AMENDING SECTIONS 20-1402 AND 20-1404, 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  
6 be 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  
11 of services with which the corporation has contracted for hospital,  
12 medical, dental or optometric services.

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

16 1. Performance of any surgical service that is covered by the terms  
17 of 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  
21 would 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  
24 would have been covered.

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

28 D. Each contract for dental or optometric services shall be so  
29 written that the corporation shall pay benefits for contracted dental or  
30 optometric 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  
34 payable with respect to a newly born child of the insured from the instant  
35 of such child's birth, to a child adopted by the insured, regardless of  
36 the age at which the child was adopted, and to a child who has been placed  
37 for adoption with the insured and for whom the application and approval  
38 procedures for adoption pursuant to section 8-105 or 8-108 have been  
39 completed to the same extent that such coverage applies to other members  
40 of the family. The coverage for newly born or adopted children or  
41 children placed for adoption shall include coverage of injury or sickness,  
42 including necessary care and treatment of medically diagnosed congenital  
43 defects and birth abnormalities. If payment of a specific premium is  
44 required to provide coverage for a child, the contract may require that  
45 notification of birth, adoption or adoption placement of the child and

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

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

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

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

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

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

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

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

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

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

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

8           3. All preexisting conditions and other limitations have been met  
9 by the insured.

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

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

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

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

32          1. Conditions of eligibility.

33          2. Coverage of dependents.

34          3. Preexisting conditions.

35          4. Termination of insurance.

36          5. Probationary periods.

37          6. Limitations.

38          7. Exceptions.

39          8. Reductions.

40          9. Elimination periods.

41          10. Requirements for replacement.

42          11. Any other condition of subscription contracts.

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

1 normal vaginal delivery or ninety-six hours following a cesarean section.  
2 The contract shall not require the provider to obtain authorization from  
3 the corporation for prescribing the minimum length of stay required by  
4 this subsection. The contract may provide that an attending provider in  
5 consultation with the mother may discharge the mother or the newborn child  
6 before the expiration of the minimum length of stay required by this  
7 subsection. The corporation shall not:

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

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

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

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

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

24 O. Nothing in subsection N of this section:

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

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

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

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

40 1. Blood glucose monitors.

41 2. Blood glucose monitors for the legally blind.

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

44 4. Insulin preparations and glucagon.

45 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
- 14 service corporation, a hospital service corporation or a hospital,
- 15 medical, dental and optometric service corporation from imposing
- 16 deductibles, coinsurance or other cost sharing in relation to benefits for
- 17 equipment or supplies for the treatment of diabetes.
- 18           R. Any hospital or medical service contract that provides coverage
- 19 for prescription drugs shall not limit or exclude coverage for any
- 20 prescription drug prescribed for the treatment of cancer on the basis that
- 21 the prescription drug has not been approved by the United States food and
- 22 drug administration for the treatment of the specific type of cancer for
- 23 which the prescription drug has been prescribed, if the prescription drug
- 24 has been recognized as safe and effective for treatment of that specific
- 25 type of cancer in one or more of the standard medical reference compendia
- 26 prescribed in subsection S of this section or medical literature that
- 27 meets the criteria prescribed in subsection S of this section. The
- 28 coverage required under this subsection includes covered medically
- 29 necessary services associated with the administration of the prescription
- 30 drug. This subsection does not:
  - 31           1. Require coverage of any prescription drug used in the treatment
  - 32 of a type of cancer if the United States food and drug administration has
  - 33 determined that the prescription drug is contraindicated for that type of
  - 34 cancer.
  - 35           2. Require coverage for any experimental prescription drug that is
  - 36 not approved for any indication by the United States food and drug
  - 37 administration.
  - 38           3. Alter any law with regard to provisions that limit the coverage
  - 39 of prescription drugs that have not been approved by the United States
  - 40 food and drug administration.
  - 41           4. Notwithstanding section 20-841.05, require reimbursement or
  - 42 coverage for any prescription drug that is not included in the drug
  - 43 formulary or list of covered prescription drugs specified in the contract.
  - 44           5. Notwithstanding section 20-841.05, prohibit a contract from
  - 45 limiting or excluding coverage of a prescription drug, if the decision to

1 limit or exclude coverage of the prescription drug is not based primarily  
2 on the coverage of prescription drugs required by this section.

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

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

7 1. The acceptable standard medical reference compendia are the  
8 following:

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

11 (b) The national comprehensive cancer network drugs and biologics  
12 compendium.

13 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24           Z. Notwithstanding subsection Y of this section, a religiously  
25 affiliated employer may require that the corporation provide a contract  
26 without coverage for specific items or services required under subsection  
27 Y of this section because providing or paying for coverage of the specific  
28 items or services is contrary to the religious beliefs of the religiously  
29 affiliated employer offering the plan. If a religiously affiliated  
30 employer objects to providing coverage for specific items or services  
31 required under subsection Y of this section, a written affidavit shall be  
32 filed with the corporation stating the objection. On receipt of the  
33 affidavit, the corporation shall issue to the religiously affiliated  
34 employer a contract that excludes coverage for specific items or services  
35 required under subsection Y of this section. The corporation shall retain  
36 the affidavit for the duration of the contract and any renewals of the  
37 contract. This subsection shall not exclude coverage for prescription  
38 contraceptive methods ordered by a health care provider with prescriptive  
39 authority for medical indications other than for contraceptive,  
40 abortifacient, abortion or sterilization purposes. A religiously  
41 affiliated employer offering the plan may state religious beliefs in its  
42 affidavit and may require the subscriber to first pay for the prescription  
43 and then submit a claim to the hospital service corporation, medical  
44 service corporation or hospital, medical, dental and optometric service  
45 corporation along with evidence that the prescription is not for a purpose

1 covered by the objection. A hospital service corporation, medical service  
2 corporation or hospital, medical, dental and optometric service  
3 corporation may charge an administrative fee for handling these claims.

4 AA. Subsection Z of this section does not authorize a religiously  
5 affiliated employer to obtain an employee's protected health information  
6 or to violate the health insurance portability and accountability act of  
7 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted  
8 pursuant to that act.

9 BB. Subsection Z of this section shall not be construed to restrict  
10 or limit any protections against employment discrimination that are  
11 prescribed in federal or state law.

12 CC. For the purposes of:

13 1. This section:

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

17 (b) "Medical foods" means modified low protein foods and metabolic  
18 formula.

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

20 (i) Formulated to be consumed or administered enterally under the  
21 supervision of a physician who is licensed pursuant to title 32, chapter  
22 13 or 17.

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

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

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

31 (d) "Modified low protein foods" means foods that are all of the  
32 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  
35 13 or 17.

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

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

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



1 services required under subsection A of this section because providing or  
2 paying for coverage of the specific items or services is contrary to the  
3 religious beliefs of the religiously affiliated employer offering the  
4 plan. If a religiously affiliated employer objects to providing coverage  
5 for specific items or services required under subsection A of this  
6 section, a written affidavit shall be filed with the health care services  
7 organization stating the objection. On receipt of the affidavit, the  
8 health care services organization shall issue to the religiously  
9 affiliated employer an evidence of coverage that excludes coverage for  
10 specific items or services required under subsection A of this section.  
11 The health care services organization shall retain the affidavit for the  
12 duration of the coverage and any renewals of the coverage.

13 C. Subsection B of this section does not exclude coverage for  
14 prescription contraceptive methods ordered by a health care provider with  
15 prescriptive authority for medical indications other than for  
16 contraceptive, abortifacient, abortion or sterilization purposes. A  
17 religiously affiliated employer offering the plan may state religious  
18 beliefs in its affidavit and may require the enrollee to first pay for the  
19 prescription and then submit a claim to the health care services  
20 organization along with evidence that the prescription is not for a  
21 purpose covered by the objection. A health care services organization may  
22 charge an administrative fee for handling claims under this subsection.

23 D. Subsections B and C of this section do not authorize a  
24 religiously affiliated employer to obtain an employee's protected health  
25 information or to violate the health insurance portability and  
26 accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) or any federal  
27 regulations adopted pursuant to that act.

28 E. Subsections B and C of this section shall not be construed to  
29 restrict or limit any protections against employment discrimination that  
30 are prescribed in federal or state law.

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

33 G. For the purposes of this section, "religiously affiliated  
34 employer" means either:

35 1. An entity for which all of the following apply:

36 (a) The entity primarily employs persons who share the religious  
37 tenets of the entity.

38 (b) The entity serves primarily persons who share the religious  
39 tenets of the entity.

40 (c) The entity is a nonprofit organization as described in section  
41 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as  
42 amended.

43 2. An entity whose articles of incorporation clearly state that it  
44 is a religiously motivated organization and whose religious beliefs are  
45 central to the organization's operating principles.



1 date of birth, adoption or adoption placement in order to have the  
2 coverage continue beyond such thirty-one day period.

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

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

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

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

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

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

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

42 7. Any contract that is issued to the insured and that provides  
43 coverage for maternity benefits shall also provide that the maternity  
44 benefits apply to the costs of the birth of any child legally adopted by  
45 the 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  
4 by 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  
7 days 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  
10 excess to any other coverage the natural mother may have for maternity  
11 benefits except coverage made available to persons pursuant to title 36,  
12 chapter 29, but not including coverage made available to persons defined  
13 as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)  
14 and (e). If such other coverage exists the agency, attorney or individual  
15 arranging the adoption shall make arrangements for the insurance to pay  
16 those costs that may be covered under that policy and shall advise the  
17 adopting parent in writing of the existence and extent of the coverage  
18 without disclosing any confidential information such as the identity of  
19 the natural parent. The insured adopting parents shall notify their  
20 insurer of the existence and 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  
35 those mothers to accept less than the minimum protections available  
36 pursuant to 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  
39 under 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

1 a manner that is less favorable than the benefits provided for any  
2 preceding 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  
7 other 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  
9 policy, except that any coinsurance or other cost sharing for any portion  
10 of a period within a hospital length of stay required pursuant to  
11 subsection B of this section shall not be greater than the coinsurance or  
12 cost sharing for any 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  
17 provide coverage for equipment and supplies that are medically necessary  
18 and that are 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  
40 treatment 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  
45 treatment of the specific type of cancer for which the prescription drug

1 has been prescribed, if the prescription drug has been recognized as safe  
2 and effective for treatment of that specific type of cancer in one or more  
3 of the standard medical reference compendia prescribed in subsection G of  
4 this 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  
9 of 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  
13 not 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  
16 of prescription drugs that have not been approved by the United States  
17 food and drug administration.

18 4. Require reimbursement or coverage for any prescription drug that  
19 is not included in the drug formulary or list of covered prescription  
20 drugs 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  
26 other cost sharing in relation to drug benefits and related medical  
27 benefits 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  
40 apply:

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

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

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

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

17 I. The metabolic disorders triggering medical foods coverage under  
18 this section shall:

19 1. Be part of the newborn screening program prescribed in section  
20 36-694.

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

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

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

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

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

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

43 1. Prescription drugs shall also provide coverage for any  
44 prescribed drug or device that is approved by the United States food and  
45 drug administration for use as a contraceptive. A group disability

1 insurer may use a drug formulary, multitiered drug formulary or list but  
 2 that formulary or list shall include oral, implant and injectable  
 3 contraceptive drugs, intrauterine devices and prescription barrier  
 4 methods. ~~if~~ The group disability insurer ~~does~~ MAY not impose deductibles,  
 5 coinsurance, copayments or other cost containment measures for  
 6 contraceptive drugs, ~~that are greater than the deductibles, coinsurance,~~  
 7 ~~copayments or other cost containment measures for other drugs on the same~~  
 8 ~~level of the formulary or list~~ INTRAUTERINE DEVICES, PRESCRIPTION BARRIER  
 9 METHODS OR MALE STERILIZATION.

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

16 M. Notwithstanding subsection L of this section, a religiously  
 17 affiliated employer may require that the insurer provide a group  
 18 disability policy without coverage for specific items or services required  
 19 under subsection L of this section because providing or paying for  
 20 coverage of the specific items or services is contrary to the religious  
 21 beliefs of the religiously affiliated employer offering the plan. If a  
 22 religiously affiliated employer objects to providing coverage for specific  
 23 items or services required under subsection L of this section, a written  
 24 affidavit shall be filed with the insurer stating the objection. On  
 25 receipt of the affidavit, the insurer shall issue to the religiously  
 26 affiliated employer a group disability policy that excludes coverage for  
 27 specific items or services required under subsection L of this section.  
 28 The insurer shall retain the affidavit for the duration of the group  
 29 disability policy and any renewals of the policy. This subsection shall  
 30 not exclude coverage for prescription contraceptive methods ordered by a  
 31 health care provider with prescriptive authority for medical indications  
 32 other than for contraceptive, abortifacient, abortion or sterilization  
 33 purposes. A religiously affiliated employer offering the policy may state  
 34 religious beliefs in its affidavit and may require the insured to first  
 35 pay for the prescription and then submit a claim to the insurer along with  
 36 evidence that the prescription is not for a purpose covered by the  
 37 objection. An insurer may charge an administrative fee for handling these  
 38 claims.

39 N. Subsection M of this section does not authorize a religiously  
 40 affiliated employer to obtain an employee's protected health information  
 41 or to violate the health insurance portability and accountability act of  
 42 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted  
 43 pursuant to that act.

1           0. Subsection M of this section shall not be construed to restrict  
2 or limit any protections against employment discrimination that are  
3 prescribed in federal or state law.

4           P. 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  
8 under 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  
14 13 or 17 or a registered nurse practitioner who is licensed pursuant to  
15 title 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  
20 nutrients contained in the foodstuffs or who has other specific nutrient  
21 requirements 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  
28 13 or 17 or a registered nurse practitioner who is licensed pursuant to  
29 title 32, chapter 15.

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

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

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

39           2. Subsection A of this section, the term "child", for purposes of  
40 initial coverage of an adopted child or a child placed for adoption but  
41 not for purposes of termination of coverage of such child, means a person  
42 WHO IS under ~~the age of~~ eighteen years OF AGE.

43           3. Subsections M and N of this section, "religiously affiliated  
44 employer" means either:

45           (a) An entity for which all of the following apply:

1 (i) The entity primarily employs persons who share the religious  
2 tenets of the entity.

3 (ii) The entity serves primarily persons who share the religious  
4 tenets of the entity.

5 (iii) The entity is a nonprofit organization as described in  
6 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as  
7 amended.

8 (b) An entity whose articles of incorporation clearly state that it  
9 is a religiously motivated organization and whose religious beliefs are  
10 central to the organization's operating principles.

11 Sec. 5. Section 20-1404, Arizona Revised Statutes, is amended to  
12 read:

13 20-1404. Blanket disability insurance; definitions

14 A. Blanket disability insurance is that form of disability  
15 insurance covering special groups of persons as enumerated in one of the  
16 following paragraphs:

17 1. Under a policy or contract issued to any common carrier or to  
18 any operator, owner or lessee of a means of transportation, which shall be  
19 deemed the policyholder, covering a group defined as all persons who may  
20 become passengers on such common carrier or means of transportation.

21 2. Under a policy or contract issued to an employer, who shall be  
22 deemed the policyholder, covering all employees or any group of employees  
23 defined by reference to hazards incident to an activity or activities or  
24 operations of the policyholder. Dependents of the employees and guests of  
25 the employer or employees may also be included where exposed to the same  
26 hazards.

27 3. Under a policy or contract issued to a college, school or other  
28 institution of learning or to the head or principal thereof, who or which  
29 shall be deemed the policyholder, covering students, teachers, employees  
30 or volunteers.

31 4. Under a policy or contract issued in the name of any volunteer  
32 fire department or any first aid, civil defense or other such volunteer  
33 group, or agency having jurisdiction thereof, which shall be deemed the  
34 policyholder, covering all or any group of the members, participants or  
35 volunteers of such fire department or first aid, civil defense or other  
36 group.

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

39 6. Under a policy or contract issued to a sports team or to a camp  
40 or sponsor thereof, which team or camp or sponsor thereof shall be deemed  
41 the policyholder, covering members, campers, employees, officials,  
42 supervisors or volunteers.

43 7. Under a policy or contract issued to an incorporated or  
44 unincorporated religious, charitable, recreational, educational or civic  
45 organization, or branch thereof, which organization shall be deemed the

1 policyholder, covering any group of members, participants or volunteers  
2 defined by reference to hazards incident to an activity or activities or  
3 operations sponsored or supervised by or on the premises of the  
4 policyholder.

5 8. Under a policy or contract issued to a newspaper or other  
6 publisher, which shall be deemed the policyholder, covering its carriers.

7 9. Under a policy or contract issued to a restaurant, hotel, motel,  
8 resort, innkeeper or other group with a high degree of potential customer  
9 liability, which shall be deemed the policyholder, covering patrons or  
10 guests.

11 10. Under a policy or contract issued to a health care provider or  
12 other arranger of health services, which shall be deemed the policyholder,  
13 covering patients, donors or surrogates provided that the coverage is not  
14 made a condition of receiving care.

15 11. Under a policy or contract issued to a bank, financial vendor or  
16 other financial institution, or to a parent holding company or to the  
17 trustee, trustees or agent designated by one or more banks, financial  
18 vendors or other financial institutions, which shall be deemed the  
19 policyholder, covering account holders, debtors, guarantors or purchasers.

20 12. Under a policy or contract issued to an incorporated or  
21 unincorporated association of persons having a common interest or calling,  
22 which association shall be deemed the policyholder, formed for purposes  
23 other than obtaining insurance, covering members of such association.

24 13. Under a policy or contract issued to a travel agency or other  
25 organization that provides travel-related services, which agency or  
26 organization shall be deemed the policyholder, to cover all persons for  
27 whom travel-related services are provided.

28 14. Under a policy or contract that is issued to any other  
29 substantially similar group and that, in the discretion of the director,  
30 may be subject to the issuance of a blanket disability policy or contract.  
31 The director may exercise discretion on an individual risk basis or class  
32 of risks, or both.

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

36 C. All benefits under any blanket disability policy shall be  
37 payable to the person insured, or to the insured's designated beneficiary  
38 or beneficiaries, or to the insured's estate, except that if the person  
39 insured is a minor, such benefits may be made payable to the insured's  
40 parent or guardian or any other person actually supporting the insured,  
41 and except that the policy may provide that all or any portion of any  
42 indemnities provided by any such policy on account of hospital, nursing,  
43 medical or surgical services, at the insurer's option, may be paid  
44 directly to the hospital or person rendering such services, but the policy  
45 may not require that the service be rendered by a particular hospital or

1 person. Payment so made shall discharge the insurer's obligation with  
2 respect to the amount of insurance so paid.

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

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

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

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

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

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

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

39 G. A blanket disability insurance policy that provides coverage for  
40 the surgical expense of a mastectomy shall also provide coverage  
41 incidental to the patient's covered mastectomy for the expense of  
42 reconstructive surgery of the breast on which the mastectomy was  
43 performed, surgery and reconstruction of the other breast to produce a  
44 symmetrical appearance, prostheses, treatment of physical complications  
45 for all stages of the mastectomy, including lymphedemas, and at least two

1 external postoperative prostheses subject to all of the terms and  
2 conditions of the policy.

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

8 1. A baseline mammogram for a woman from age thirty-five to  
9 thirty-nine.

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

13 3. A mammogram every year for a woman WHO IS fifty years of age and  
14 over.

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

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

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

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

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

27 J. The coverage prescribed by subsection I of this section is  
28 excess to any other coverage the natural mother may have for maternity  
29 benefits except coverage made available to persons pursuant to title 36,  
30 chapter 29, but not including coverage made available to persons defined  
31 as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)  
32 and (e). If such other coverage exists the agency, attorney or individual  
33 arranging the adoption shall make arrangements for the insurance to pay  
34 those costs that may be covered under that policy and shall advise the  
35 adopting parent in writing of the existence and extent of the coverage  
36 without disclosing any confidential information such as the identity of  
37 the natural parent. The insured adopting parents shall notify their  
38 insurer of the existence and 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  
44 the 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  
8 those mothers to accept less than the minimum protections available  
9 pursuant to 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  
12 under 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  
18 a manner that is less favorable than the benefits provided for any  
19 preceding 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  
24 other 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  
27 portion of a period within a hospital length of stay required pursuant to  
28 subsection K of this section shall not be greater than the coinsurance or  
29 cost sharing 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  
32 subsection K of this section.

33 M. Any contract that provides coverage for diabetes shall also  
34 provide coverage for equipment and supplies that are medically necessary  
35 and that are 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  
12 treatment 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  
17 treatment of the specific type of cancer for which the prescription drug  
18 has been prescribed, if the prescription drug has been recognized as safe  
19 and effective for treatment of that specific type of cancer in one or more  
20 of the standard medical reference compendia prescribed in subsection P of  
21 this 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  
26 of 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  
30 not 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  
33 of prescription drugs that have not been approved by the United States  
34 food and drug administration.

35           4. Require reimbursement or coverage for any prescription drug that  
36 is not included in the drug formulary or list of covered prescription  
37 drugs 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  
43 other cost sharing in relation to drug benefits and related medical  
44 benefits 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  
13 apply:  
14 (a) At least two articles from major peer reviewed professional  
15 medical journals have recognized, based on scientific or medical criteria,  
16 the drug's safety and effectiveness for treatment of the indication for  
17 which the drug has been prescribed.  
18 (b) No article from a major peer reviewed professional medical  
19 journal has concluded, based on scientific or medical criteria, that the  
20 drug is unsafe or ineffective or that the drug's safety and effectiveness  
21 cannot be determined for the treatment of the indication for which the  
22 drug has been prescribed.  
23 (c) The literature meets the uniform requirements for manuscripts  
24 submitted to biomedical journals established by the international  
25 committee of medical journal editors or is published in a journal  
26 specified by the United States department of health and human services as  
27 acceptable peer reviewed medical literature pursuant to section  
28 186(t)(2)(B) of the social security act (42 United States Code section  
29 1395x(t)(2)(B)).  
30 Q. Any contract that is offered by a blanket disability insurer and  
31 that contains a prescription drug benefit shall provide coverage of  
32 medical foods to treat inherited metabolic disorders as provided by this  
33 section.  
34 R. The metabolic disorders triggering medical foods coverage under  
35 this section shall:  
36 1. Be part of the newborn screening program prescribed in section  
37 36-694.  
38 2. Involve amino acid, carbohydrate or fat metabolism.  
39 3. Have medically standard methods of diagnosis, treatment and  
40 monitoring including quantification of metabolites in blood, urine or  
41 spinal fluid or enzyme or DNA confirmation in tissues.  
42 4. Require specially processed or treated medical foods that are  
43 generally available only under the supervision and direction of a  
44 physician who is licensed pursuant to title 32, chapter 13 or 17 or a  
45 registered nurse practitioner who is licensed pursuant to title 32,

1 chapter 15, that must be consumed throughout life and without which the  
2 person may suffer serious mental or physical impairment.

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

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

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

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

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

33 V. Notwithstanding subsection U of this section, a religiously  
34 affiliated employer may require that the insurer provide a blanket  
35 disability policy without coverage for specific items or services required  
36 under subsection U of this section because providing or paying for  
37 coverage of the specific items or services is contrary to the religious  
38 beliefs of the religiously affiliated employer offering the plan. If a  
39 religiously affiliated employer objects to providing coverage for specific  
40 items or services required under subsection U of this section, a written  
41 affidavit shall be filed with the insurer stating the objection. On  
42 receipt of the affidavit, the insurer shall issue to the religiously  
43 affiliated employer a blanket disability policy that excludes coverage for  
44 specific items or services required under subsection U of this section.  
45 The insurer shall retain the affidavit for the duration of the blanket

1 disability policy and any renewals of the policy. This subsection shall  
2 not exclude coverage for prescription contraceptive methods ordered by a  
3 health care provider with prescriptive authority for medical indications  
4 other than for contraceptive, abortifacient, abortion or sterilization  
5 purposes. A religiously affiliated employer offering the policy may state  
6 religious beliefs in its affidavit and may require the insured to first  
7 pay for the prescription and then submit a claim to the insurer along with  
8 evidence that the prescription is not for a purpose covered by the  
9 objection. An insurer may charge an administrative fee for handling these  
10 claims under this subsection.

11 W. Subsection V of this section does not authorize a religiously  
12 affiliated employer to obtain an employee's protected health information  
13 or to violate the health insurance portability and accountability act of  
14 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted  
15 pursuant to that act.

16 X. Subsection V of this section shall not be construed to restrict  
17 or limit any protections against employment discrimination that are  
18 prescribed in federal or state law.

19 Y. For the purposes of:

20 1. This section:

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

24 (b) "Medical foods" means modified low protein foods and metabolic  
25 formula.

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

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

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

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

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

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

41 (i) Formulated to be consumed or administered enterally under the  
42 supervision of a physician who is licensed pursuant to title 32, chapter  
43 13 or 17 or a registered nurse practitioner who is licensed pursuant to  
44 title 32, chapter 15.

- 1           (ii) Processed or formulated to contain less than one gram of  
2 protein per unit of serving, but does not include a natural food that is  
3 naturally low in protein.
- 4           (iii) Administered for the medical and nutritional management of a  
5 person who has limited capacity to metabolize foodstuffs or certain  
6 nutrients contained in the foodstuffs or who has other specific nutrient  
7 requirements as established by medical evaluation.
- 8           (iv) Essential to a person's optimal growth, health and metabolic  
9 homeostasis.
- 10          2. Subsection E of this section, the term "child", for purposes of  
11 initial coverage of an adopted child or a child placed for adoption but  
12 not for purposes of termination of coverage of such child, means a person  
13 WHO IS under eighteen years of age.
- 14          3. Subsections V and W of this section, "religiously affiliated  
15 employer" means either:
- 16           (a) An entity for which all of the following apply:
- 17           (i) The entity primarily employs persons who share the religious  
18 tenets of the entity.
- 19           (ii) The entity serves primarily persons who share the religious  
20 tenets of the entity.
- 21           (iii) The entity is a nonprofit organization as described in  
22 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as  
23 amended.
- 24           (b) An entity whose articles of incorporation clearly state that it  
25 is a religiously motivated organization and whose religious beliefs are  
26 central to the organization's operating principles.