

REFERENCE TITLE: health insurance coverage; insulin

State of Arizona
Senate
Fifty-sixth Legislature
First Regular Session
2023

SB 1216

Introduced by
Senator Gabaldón

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1402, 20-1404 AND 20-2325,
ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE 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~~ A corporation may NOT cancel or refuse to renew any
19 subscriber's contract without giving notice of such cancellation or
20 nonrenewal to the subscriber under such contract. A notice by the
21 corporation to the subscriber of cancellation or nonrenewal of a
22 subscription contract shall be mailed to the named subscriber at least
23 forty-five days before the effective date of such cancellation or
24 nonrenewal. The notice shall include or be accompanied by a statement in
25 writing of the reasons for such action by the corporation. Failure of the
26 corporation to comply with this subsection shall invalidate any
27 cancellation or nonrenewal except a cancellation or nonrenewal for
28 nonpayment of premium.

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

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

42 1. A baseline mammogram for a woman from age thirty-five to
43 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
8 the 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
12 by the insured.

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

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

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

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

35 1. Conditions of eligibility.

36 2. Coverage of dependents.

37 3. Preexisting conditions.

38 4. Termination of insurance.

39 5. Probationary periods.

40 6. Limitations.

41 7. Exceptions.

42 8. Reductions.

43 9. Elimination periods.

44 10. Requirements for replacement.

45 11. Any other condition of subscription contracts.

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

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

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

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

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

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

27 O. ~~Nothing in~~ Subsection N of this section **DOES NOT**:

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

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

39 3. ~~Prevents~~ **PREVENT** a corporation from negotiating the level and
40 type of reimbursement with a provider for care provided in accordance with
41 subsection N of this section.

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

45 1. Blood glucose monitors.

1 2. Blood glucose monitors for the legally blind.
2 3. Test strips for glucose monitors and visual reading and urine
3 testing strips.
4 4. Insulin preparations and glucagon.
5 5. Insulin cartridges.
6 6. Drawing up devices and monitors for the visually impaired.
7 7. Injection aids.
8 8. Insulin cartridges for the legally blind.
9 9. Syringes and lancets, including automatic lancing devices.
10 10. Prescribed oral agents for controlling blood sugar that are
11 included on the plan formulary.
12 11. To the extent coverage is required under medicare, podiatric
13 appliances for prevention of complications associated with diabetes.
14 12. Any other device, medication, equipment or supply for which
15 coverage is required under medicare from and after January 1, 1999. The
16 coverage required in this paragraph is effective six months after the
17 coverage is required under medicare.
18 Q. ~~Nothing in~~ Subsection P of this section ~~prohibits~~ DOES NOT
19 PROHIBIT a medical service corporation, a hospital service corporation or
20 a hospital, medical, dental and optometric service corporation from
21 imposing deductibles, coinsurance or other cost sharing in relation to
22 benefits for equipment or supplies for the treatment of diabetes, EXCEPT
23 THAT A MEDICAL SERVICE CORPORATION, A HOSPITAL SERVICE CORPORATION OR A
24 HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION SHALL LIMIT
25 THE TOTAL AMOUNT THAT A SUBSCRIBER MUST PAY FOR A COVERED PRESCRIPTION
26 INSULIN DRUG TO NOT MORE THAN \$35 PER THIRTY-DAY SUPPLY OF INSULIN,
27 REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE
28 SUBSCRIBER'S PRESCRIPTION. FOR THE PURPOSES OF THIS SUBSECTION,
29 "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED
30 IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO A
31 SUBSCRIBER TO TREAT THE SUBSCRIBER'S CONDITION, THAT CONTAINS INSULIN AND
32 THAT IS USED TO TREAT DIABETES.
33 R. Any hospital or medical service contract that provides coverage
34 for prescription drugs shall not limit or exclude coverage for any
35 prescription drug prescribed for the treatment of cancer on the basis that
36 the prescription drug has not been approved by the United States food and
37 drug administration for the treatment of the specific type of cancer for
38 which the prescription drug has been prescribed, if the prescription drug
39 has been recognized as safe and effective for treatment of that specific
40 type of cancer in one or more of the standard medical reference compendia
41 prescribed in subsection S of this section or medical literature that
42 meets the criteria prescribed in subsection S of this section. The
43 coverage required under this subsection includes covered medically
44 necessary services associated with the administration of the prescription
45 drug. This subsection does not:

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

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

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

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

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

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

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

22 1. The acceptable standard medical reference compendia are the
23 following:

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

26 (b) The national comprehensive cancer network drugs and biologics
27 compendium.

28 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

43 (c) The literature meets the uniform requirements for manuscripts
44 submitted to biomedical journals established by the international
45 committee of medical journal editors or is published in a journal

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

5 T. A corporation shall not issue or deliver any advertising matter
6 or sales material to any person in this state until the corporation files
7 the advertising matter or sales material with the director. This
8 subsection does not require a corporation to have the prior approval of
9 the director to issue or deliver the advertising matter or sales
10 material. If the director finds that the advertising matter or sales
11 material, in whole or in part, is false, deceptive or misleading, the
12 director may issue an order disapproving the advertising matter or sales
13 material, directing the corporation to cease and desist from issuing,
14 circulating, displaying or using the advertising matter or sales material
15 within a period of time specified by the director but not less than ten
16 days and imposing any penalties prescribed in this title. At least five
17 days before issuing an order pursuant to this subsection, the director
18 shall provide the corporation with a written notice of the basis of the
19 order to provide the corporation with an opportunity to cure the alleged
20 deficiency in the advertising matter or sales material within a single
21 ~~five-day~~ FIVE-DAY period for the particular advertising matter or sales
22 material at issue. The corporation may appeal the director's order
23 pursuant to title 41, chapter 6, article 10. Except as otherwise provided
24 in this subsection, a corporation may obtain a stay of the effectiveness
25 of the order as prescribed in section 20-162. If the director certifies
26 in the order and provides a detailed explanation of the reasons in support
27 of the certification that continued use of the advertising matter or sales
28 material poses a threat to the health, safety or welfare of the public,
29 the order may be entered immediately without opportunity for cure and the
30 effectiveness of the order is not stayed pending the hearing on the notice
31 of appeal but the hearing shall be promptly instituted and determined.

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

36 V. The metabolic disorders triggering medical foods coverage under
37 this section shall:

38 1. Be part of the newborn screening program prescribed in section
39 36-694.

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

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

44 4. Require specially processed or treated medical foods that are
45 generally available only under the supervision and direction of a

1 physician who is licensed pursuant to title 32, chapter 13 or 17 or a
2 registered nurse practitioner who is licensed pursuant to title 32,
3 chapter 15, that must be consumed throughout life and without which the
4 person may suffer serious mental or physical impairment.

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

9 X. A hospital service corporation or medical service corporation
10 shall cover at least fifty ~~per cent~~ PERCENT of the cost of medical foods
11 prescribed to treat inherited metabolic disorders and covered pursuant to
12 this section. A hospital service corporation or medical service
13 corporation may limit the maximum annual benefit for medical foods under
14 this section to ~~five thousand dollars~~ \$5,000, which applies to the cost of
15 all prescribed modified low protein foods and metabolic formula.

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

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

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

36 3. This subsection does not apply to contracts issued to
37 individuals on a nongroup basis.

38 Z. Notwithstanding subsection Y of this section, a religiously
39 affiliated employer may require that the corporation provide a contract
40 without coverage for specific items or services required under subsection
41 Y of this section because providing or paying for coverage of the specific
42 items or services is contrary to the religious beliefs of the religiously
43 affiliated employer offering the plan. If a religiously affiliated
44 employer objects to providing coverage for specific items or services
45 required under subsection Y of this section, a written affidavit shall be

1 filed with the corporation stating the objection. On receipt of the
2 affidavit, the corporation shall issue to the religiously affiliated
3 employer a contract that excludes coverage for specific items or services
4 required under subsection Y of this section. The corporation shall retain
5 the affidavit for the duration of the contract and any renewals of the
6 contract. This subsection shall not exclude coverage for prescription
7 contraceptive methods ordered by a health care provider with prescriptive
8 authority for medical indications other than for contraceptive,
9 abortifacient, abortion or sterilization purposes. A religiously
10 affiliated employer offering the plan may state religious beliefs in its
11 affidavit and may require the subscriber to first pay for the prescription
12 and then submit a claim to the hospital service corporation, medical
13 service corporation or hospital, medical, dental and optometric service
14 corporation along with evidence that the prescription is not for a purpose
15 covered by the objection. A hospital service corporation, medical service
16 corporation or hospital, medical, dental and optometric service
17 corporation may charge an administrative fee for handling these claims.

18 AA. Subsection Z of this section does not authorize a religiously
19 affiliated employer to obtain an employee's protected health information
20 or to violate the health insurance portability and accountability act of
21 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
22 pursuant to that act.

23 BB. Subsection Z of this section ~~shall~~ DOES not ~~be construed to~~
24 restrict or limit any protections against employment discrimination that
25 are prescribed in federal or state law.

26 CC. For the purposes of:

27 1. This section:

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

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

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

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

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

39 (iii) Administered for the medical and nutritional management of a
40 person who has limited capacity to metabolize foodstuffs or certain
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 (d) "Modified low protein foods" means foods that are all of the
2 following:

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

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

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

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

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

19 3. Subsections Z and AA of this section, "religiously affiliated
20 employer" means either:

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

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

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

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

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

32 Sec. 2. Section 20-1057, Arizona Revised Statutes, is amended to
33 read:

34 20-1057. Evidence of coverage by health care services
35 organizations; renewability; definitions

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

38 B. Any contract, except accidental death and dismemberment, applied
39 for that provides family coverage shall also provide, as to such coverage
40 of family members, that the benefits applicable for children shall be
41 payable with respect to a newly born child of the enrollee from the
42 instant of such child's birth, to a child adopted by the enrollee,
43 regardless of the age at which the child was adopted, and to a child who
44 has been placed for adoption with the enrollee and for whom the
45 application and approval procedures for adoption pursuant to section 8-105

or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

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

D. ~~NO~~ AN evidence of coverage or amendment to the coverage shall NOT be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment to the coverage has been filed with and approved by the director.

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

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

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

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

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

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

G. The director shall approve any form of evidence of coverage if the requirements of subsections E and F of this section are met. It is unlawful to issue such form until approved. If the director does not disapprove any such form within forty-five days after the filing of the form, it is deemed approved. If the director disapproves a form of evidence of coverage, the director shall notify the health care services organization. In the notice, the director shall specify the reasons for the director's disapproval. The director shall grant a hearing on such

1 disapproval within fifteen days after a request for a hearing in writing
2 is received from the health care services organization.

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

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

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

44 1. A baseline mammogram for a woman from age thirty-five to
45 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 K. Any contract that is issued to the enrollee 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
8 the enrollee if all the following are true:

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

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

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

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

17 L. The coverage prescribed by subsection K of this section is
18 excess to any other coverage the natural mother may have for maternity
19 benefits except coverage made available to persons pursuant to title 36,
20 chapter 29. If such other coverage exists the agency, attorney or
21 individual arranging the adoption shall make arrangements for the
22 insurance to pay those costs that may be covered under that policy and
23 shall advise the adopting parent in writing of the existence and extent of
24 the coverage without disclosing any confidential information such as the
25 identity of the natural parent. The enrollee adopting parents shall
26 notify their health care services organization of the existence and extent
27 of the other coverage. A health care services organization is not
28 required to pay any costs in excess of the amounts it would have been
29 obligated to pay to its hospitals and providers if the natural mother and
30 child had received the maternity and newborn care directly from or through
31 that health care services organization.

32 M. Each health care services organization shall offer membership to
33 the following in a conversion plan that provides the basic health care
34 benefits required by the director:

35 1. Each enrollee including the enrollee's enrolled dependents
36 leaving a group.

37 2. Each enrollee and the enrollee's dependents who would otherwise
38 cease to be eligible for membership because of the age of the enrollee or
39 the enrollee's dependents or the death or the dissolution of marriage of
40 an enrollee.

41 N. A health care services organization shall not cancel or nonrenew
42 an evidence of coverage issued to an individual on a nongroup basis,
43 including a conversion plan, except for any of the following reasons and
44 in compliance with the notice and disclosure requirements contained in
45 subsection H of this section:

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

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

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

11 4. If the health care services organization offers a health care
12 plan in this state through a network plan, the individual no longer
13 resides, lives or works in the service area served by the network plan or
14 in an area for which the health care services organization is authorized
15 to transact business but only if the coverage is terminated uniformly
16 without regard to any health status-related factor of the covered
17 individual.

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

23 O. A conversion plan may be modified if the modification complies
24 with the notice and disclosure provisions for cancellation and nonrenewal
25 under subsection H of this section. A modification of a conversion plan
26 that has already been issued shall not result in the effective elimination
27 of any benefit originally included in the conversion plan.

28 P. Any person who is a United States armed forces reservist, who is
29 ordered to active military duty on or after August 22, 1990 and who was
30 enrolled in a health care plan shall have the right to reinstate such
31 coverage on release from active military duty subject to the following
32 conditions:

33 1. The reservist shall make written application to the health plan
34 within ninety days of discharge from active military duty or within one
35 year of hospitalization continuing after discharge. Coverage shall be
36 effective on receipt of the application by the health plan.

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

40 Q. The director shall adopt emergency rules that are applicable to
41 persons who are leaving active service in the armed forces of the United
42 States and returning to civilian status consistent with subsection P of
43 this section and that include:

44 1. Conditions of eligibility.

45 2. Coverage of dependents.

1 3. Preexisting conditions.
2 4. Termination of insurance.
3 5. Probationary periods.
4 6. Limitations.
5 7. Exceptions.
6 8. Reductions.
7 9. Elimination periods.
8 10. Requirements for replacement.
9 11. Any other conditions of evidences of coverage.
10 R. Any contract that provides maternity benefits shall not restrict
11 benefits for any hospital length of stay in connection with childbirth for
12 the mother or the newborn child to less than forty-eight hours following a
13 normal vaginal delivery or ninety-six hours following a cesarean section.
14 The contract shall not require the provider to obtain authorization from
15 the health care services organization for prescribing the minimum length
16 of stay required by this subsection. The contract may provide that an
17 attending provider in consultation with the mother may discharge the
18 mother or the newborn child before the expiration of the minimum length of
19 stay required by this subsection. The health care services organization
20 shall not:
21 1. Deny the mother or the newborn child eligibility or continued
22 eligibility to enroll or to renew coverage under the terms of the contract
23 solely for the purpose of avoiding the requirements of this subsection.
24 2. Provide monetary payments or rebates to mothers to encourage
25 those mothers to accept less than the minimum protections available
26 pursuant to this subsection.
27 3. Penalize or otherwise reduce or limit the reimbursement of an
28 attending provider because that provider provided care to any insured
29 under the contract in accordance with this subsection.
30 4. Provide monetary or other incentives to an attending provider to
31 induce that provider to provide care to an insured under the contract in a
32 manner that is inconsistent with this subsection.
33 5. Except as described in subsection S of this section, restrict
34 benefits for any portion of a period within the minimum length of stay in
35 a manner that is less favorable than the benefits provided for any
36 preceding portion of that stay.
37 S. ~~Nothing in~~ Subsection R of this section **DOES NOT**:
38 1. ~~Requires~~ **REQUIRE** a mother to give birth in a hospital or to stay
39 in the hospital for a fixed period of time following the birth of the
40 child.
41 2. ~~Prevents~~ **PREVENT** a health care services organization from
42 imposing deductibles, coinsurance or other cost sharing in relation to
43 benefits for hospital lengths of stay in connection with childbirth for a
44 mother or a newborn child under the contract, except that any coinsurance
45 or other cost sharing for any portion of a period within a hospital length

of stay required pursuant to subsection R of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

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

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

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

U. ~~Nothing in~~ Subsection T of this section DOES NOT:

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

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

3. ~~Prohibits~~ PROHIBIT a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes, EXCEPT THAT A HEALTH CARE SERVICES ORGANIZATION SHALL LIMIT THE TOTAL AMOUNT THAT A MEMBER OR ENROLLEE MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN \$35 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE MEMBER'S OR ENROLLEE'S PRESCRIPTION. FOR THE PURPOSES OF THIS PARAGRAPH, "PRESCRIPTION INSULIN

1 DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT
2 IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO A MEMBER OR ENROLLEE TO
3 TREAT A MEMBER'S OR ENROLLEE'S CONDITION, THAT CONTAINS INSULIN AND THAT
4 IS USED TO TREAT DIABETES.

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

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

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

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

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

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

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

40 W. For the purposes of subsection V of this section:

41 1. The acceptable standard medical reference compendia are the
42 following:

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

1 (b) The national comprehensive cancer network drugs and biologics
2 compendium.

3 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

subsection, a health care services organization may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

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

Z. The metabolic disorders triggering medical foods coverage under this section shall:

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

BB. A health care services organization shall cover at least fifty percent of the cost of medical foods prescribed to treat inherited metabolic disorders and covered pursuant to this section. An organization may limit the maximum annual benefit for medical foods under this section to \$5,000, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

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

DD. For the purposes of:

1. This section:

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

4 (b) "Medical foods" means modified low protein foods and metabolic
5 formula.

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

7 (i) Formulated to be consumed or administered enterally under the
8 supervision of a physician who is licensed pursuant to title 32, chapter
9 13 or 17 or a registered nurse practitioner who is licensed pursuant to
10 title 32, chapter 15.

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

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

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

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

21 (i) Formulated to be consumed or administered enterally under the
22 supervision of a physician who is licensed pursuant to title 32, chapter
23 13 or 17 or a registered nurse practitioner who is licensed pursuant to
24 title 32, chapter 15.

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

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

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

34 2. Subsection B of this section, "child", for purposes of initial
35 coverage of an adopted child or a child placed for adoption but not for
36 purposes of termination of coverage of such child, means a person who is
37 under eighteen years of age.

38 Sec. 3. Section 20-1342, Arizona Revised Statutes, is amended to
39 read:

40 20-1342. Scope and format of policy; definitions

41 A. A policy of disability insurance shall not be delivered or
42 issued for delivery to any person in this state unless it otherwise
43 complies with this title and complies with the following:

44 1. The entire money and other considerations shall be expressed in
45 the policy.

2. The time when the insurance takes effect and terminates shall be expressed in the policy.

3. It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, on the application of the policyholder or the policyholder's spouse, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age that does not exceed nineteen years and any other person dependent ~~upon~~ ON the policyholder. Any policy, except accidental death and dismemberment, applied for that provides family coverage ~~shall~~, as to such coverage of family members, shall also provide that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth, to a child adopted by the insured, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the insured and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth, adoption or adoption placement of the child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (a) The child is adopted within one year of birth.
- (b) The insured is legally obligated to pay the costs of birth.
- (c) All preexisting conditions and other limitations have been met by the insured.

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

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

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

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

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

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

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

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

C. ~~Nothing in~~ Subsection B of this section **DOES NOT**:

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

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

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

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

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

E. ~~Nothing in~~ Subsection D of this section **DOES NOT**:

1. ~~Prohibits~~ **PROHIBIT** a disability insurer from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes, **EXCEPT THAT A DISABILITY INSURER SHALL LIMIT THE TOTAL AMOUNT THAT AN INSURED MUST PAY**

FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN \$35 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE INSURED'S PRESCRIPTION. FOR THE PURPOSES OF THIS PARAGRAPH, "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO AN INSURED TO TREAT THE INSURED'S CONDITION, THAT CONTAINS INSULIN AND THAT IS USED TO TREAT DIABETES.

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

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

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

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

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

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

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

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

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

1. The acceptable standard medical reference compendia are the 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
10 apply:

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

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

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

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

31 I. The metabolic disorders triggering medical foods coverage under
32 this section shall:

33 1. Be part of the newborn screening program prescribed in section
34 36-694.

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

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

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

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

K. An insurer shall cover at least fifty ~~per cent~~ PERCENT of the cost of medical foods prescribed to treat inherited metabolic disorders and covered pursuant to this section. An insurer may limit the maximum annual benefit for medical foods under this section to ~~five thousand dollars~~ \$5,000, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

L. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Sec. 4. Section 20-1402, Arizona Revised Statutes, is amended to
8 read:

9 20-1402. Provisions of group disability policies; definitions

10 A. Each group disability policy shall contain in substance the
11 following provisions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 C. ~~Nothing in~~ Subsection B of this section DOES NOT:
2 1. ~~Requires~~ REQUIRE a mother to give birth in a hospital or to stay
3 in the hospital for a fixed period of time following the birth of the
4 child.
5 2. ~~Prevents~~ PREVENT an insurer from imposing deductibles,
6 coinsurance or other cost sharing in relation to benefits for hospital
7 lengths of stay in connection with childbirth for a mother or a newborn
8 child under the policy, except that any coinsurance or other cost sharing
9 for any portion of a period within a hospital length of stay required
10 pursuant to subsection B of this section shall not be greater than the
11 coinsurance or cost sharing for any preceding portion of that stay.
12 3. ~~Prevents~~ PREVENT an insurer from negotiating the level and type
13 of reimbursement with a provider for care provided in accordance with
14 subsection B of this section.
15 D. Any contract that provides coverage for diabetes shall also
16 provide coverage for equipment and supplies that are medically necessary
17 and that are prescribed by a health care provider including:
18 1. Blood glucose monitors.
19 2. Blood glucose monitors for the legally blind.
20 3. Test strips for glucose monitors and visual reading and urine
21 testing strips.
22 4. Insulin preparations and glucagon.
23 5. Insulin cartridges.
24 6. Drawing up devices and monitors for the visually impaired.
25 7. Injection aids.
26 8. Insulin cartridges for the legally blind.
27 9. Syringes and lancets including automatic lancing devices.
28 10. Prescribed oral agents for controlling blood sugar that are
29 included on the plan formulary.
30 11. To the extent coverage is required under medicare, podiatric
31 appliances for prevention of complications associated with diabetes.
32 12. Any other device, medication, equipment or supply for which
33 coverage is required under medicare from and after January 1, 1999. The
34 coverage required in this paragraph is effective six months after the
35 coverage is required under medicare.
36 E. ~~Nothing in~~ Subsection D of this section ~~prohibits~~ DOES NOT
37 PROHIBIT a group disability insurer from imposing deductibles, coinsurance
38 or other cost sharing in relation to benefits for equipment or supplies
39 for the treatment of diabetes, EXCEPT THAT A GROUP DISABILITY INSURER
40 SHALL LIMIT THE TOTAL AMOUNT THAT AN INSURED MUST PAY FOR A COVERED
41 PRESCRIPTION INSULIN DRUG TO NOT MORE THAN \$35 PER THIRTY-DAY SUPPLY OF
42 INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE
43 INSURED'S PRESCRIPTION. FOR THE PURPOSES OF THIS SUBSECTION,
44 "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED
45 IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO AN

1 INSURED TO TREAT THE INSURED'S CONDITION, THAT CONTAINS INSULIN AND THAT
2 IS USED TO TREAT DIABETES.

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

15 1. Require coverage of any prescription drug used in the treatment
16 of a type of cancer if the United States food and drug administration has
17 determined that the prescription drug is contraindicated for that type of
18 cancer.

19 2. Require coverage for any experimental prescription drug that is
20 not approved for any indication by the United States food and drug
21 administration.

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

25 4. Require reimbursement or coverage for any prescription drug that
26 is not included in the drug formulary or list of covered prescription
27 drugs specified in the contract.

28 5. Prohibit a contract from limiting or excluding coverage of a
29 prescription drug, if the decision to limit or exclude coverage of the
30 prescription drug is not based primarily on the coverage of prescription
31 drugs required by this section.

32 6. Prohibit the use of deductibles, coinsurance, copayments or
33 other cost sharing in relation to drug benefits and related medical
34 benefits offered.

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

36 1. The acceptable standard medical reference compendia are the
37 following:

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

40 (b) The national comprehensive cancer network drugs and biologics
41 compendium.

42 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

23 I. The metabolic disorders triggering medical foods coverage under
24 this section shall:

25 1. Be part of the newborn screening program prescribed in section
26 36-694.

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

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

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

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

42 K. An insurer shall cover at least fifty ~~per cent~~ PERCENT of the
43 cost of medical foods prescribed to treat inherited metabolic disorders
44 and covered pursuant to this section. An insurer may limit the maximum
45 annual benefit for medical foods under this section to ~~five thousand~~

~~dollars~~ \$5,000, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

L. Any group disability policy that provides coverage for:

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

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

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

N. Subsection M of this section does not authorize a religiously affiliated employer to obtain an employee's protected health information

1 or to violate the health insurance portability and accountability act of
2 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
3 pursuant to that act.

4 O. Subsection M of this section shall not be construed to restrict
5 or limit any protections against employment discrimination that are
6 prescribed in federal or state law.

7 P. For the purposes of:

8 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

7. Under a policy or contract issued to an incorporated or unincorporated religious, charitable, recreational, educational or civic organization, or branch thereof, which organization shall be deemed the policyholder, covering any group of members, participants or volunteers defined by reference to hazards incident to an activity or activities or operations sponsored or supervised by or on the premises of the policyholder.

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

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

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

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

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

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

14. Under a policy or contract issued to a qualified marketplace platform, which is deemed the policyholder, covering qualified marketplace contractors that have executed a written contract with the qualified marketplace platform. For the purposes of this paragraph, "qualified marketplace contractor" and "qualified marketplace platform" have the same meanings prescribed in section 20-485.

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

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

1 C. All benefits under any blanket disability policy shall be
2 payable to the person insured, or to the insured's designated beneficiary
3 or beneficiaries, or to the insured's estate, except that if the person
4 insured is a minor, such benefits may be made payable to the insured's
5 parent or guardian or any other person actually supporting the insured,
6 and except that the policy may provide that all or any portion of any
7 indemnities provided by any such policy on account of hospital, nursing,
8 medical or surgical services, at the insurer's option, may be paid
9 directly to the hospital or person rendering such services, but the policy
10 may not require that the service be rendered by a particular hospital or
11 person. Payment so made shall discharge the insurer's obligation with
12 respect to the amount of insurance so paid.

13 D. ~~Nothing contained in~~ This section ~~shall be deemed to~~ DOES NOT
14 affect the legal liability of policyholders for the death of or injury to
15 any member of the group.

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

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

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

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

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

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

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

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

18 1. A baseline mammogram for a woman from age thirty-five to
19 thirty-nine.

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

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

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

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

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

30 3. All preexisting conditions and other limitations have been met
31 by the insured.

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

36 J. The coverage prescribed by subsection I of this section is
37 excess to any other coverage the natural mother may have for maternity
38 benefits except coverage made available to persons pursuant to title 36,
39 chapter 29. If such other coverage exists the agency, attorney or
40 individual arranging the adoption shall make arrangements for the
41 insurance to pay those costs that may be covered under that policy and
42 shall advise the adopting parent in writing of the existence and extent of
43 the coverage without disclosing any confidential information such as the
44 identity of the natural parent. The insured adopting parents shall notify
45 their insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

L. ~~Nothing in~~ Subsection K of this section **DOES NOT**:

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

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

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

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

1. Blood glucose monitors.

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

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

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

N. ~~Nothing in~~ Subsection M of this section ~~prohibits~~ DOES NOT PROHIBIT a blanket disability insurer from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes, EXCEPT THAT A BLANKET DISABILITY INSURER SHALL LIMIT THE TOTAL AMOUNT THAT AN INSURED MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN \$35 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE INSURED'S PRESCRIPTION. FOR THE PURPOSES OF THIS SUBSECTION, "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO AN INSURED TO TREAT THE INSURED'S CONDITION, THAT CONTAINS INSULIN AND THAT IS USED TO TREAT DIABETES.

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

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

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

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

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

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

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

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

18 1. The acceptable standard medical reference compendia are the
19 following:

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

22 (b) The national comprehensive cancer network drugs and biologics
23 compendium.

24 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

39 (c) The literature meets the uniform requirements for manuscripts
40 submitted to biomedical journals established by the international
41 committee of medical journal editors or is published in a journal
42 specified by the United States department of health and human services as
43 acceptable peer reviewed medical literature pursuant to section
44 186(t)(2)(B) of the social security act (42 United States Code section
45 1395x(t)(2)(B)).

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

5 R. The metabolic disorders triggering medical foods coverage under
6 this section shall:

7 1. Be part of the newborn screening program prescribed in section
8 36-694.

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

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

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

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

24 T. An insurer shall cover at least fifty percent of the cost of
25 medical foods prescribed to treat inherited metabolic disorders and
26 covered pursuant to this section. An insurer may limit the maximum annual
27 benefit for medical foods under this section to \$5,000, which applies to
28 the cost of all prescribed modified low protein foods and metabolic
29 formula.

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

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

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

related to the use of approved United States food and drug administration prescription contraceptive methods to prevent unintended pregnancies.

V. Notwithstanding subsection U of this section, a religiously affiliated employer may require that the insurer provide a blanket disability policy without coverage for specific items or services required under subsection U of this section because providing or paying for coverage of the specific items or services is contrary to the religious beliefs of the religiously affiliated employer offering the plan. If a religiously affiliated employer objects to providing coverage for specific items or services required under subsection U of this section, a written affidavit shall be filed with the insurer stating the objection. On receipt of the affidavit, the insurer shall issue to the religiously affiliated employer a blanket disability policy that excludes coverage for specific items or services required under subsection U of this section. The insurer shall retain the affidavit for the duration of the blanket disability policy and any renewals of the policy. This subsection shall not exclude coverage for prescription contraceptive methods ordered by a health care provider with prescriptive authority for medical indications other than for contraceptive, abortifacient, abortion or sterilization purposes. A religiously affiliated employer offering the policy may state religious beliefs in its affidavit and may require the insured to first pay for the prescription and then submit a claim to the insurer along with evidence that the prescription is not for a purpose covered by the objection. An insurer may charge an administrative fee for handling these claims under this subsection.

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

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

Y. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

28 3. Subsections V and W of this section, "religiously affiliated
29 employer" means either:

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

31 (i) The entity primarily employs persons who share the religious
32 tenets of the entity.

33 (ii) The entity serves primarily persons who share the religious
34 tenets of the entity.

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

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

41 Sec. 6. Section 20-2325, Arizona Revised Statutes, is amended to
42 read:

43 20-2325. Diabetes; equipment; supplies

44 A. Any health benefits plan that is offered by an accountable
45 health plan and that provides coverage for diabetes shall also provide

1 coverage for equipment and supplies that are medically necessary and that
2 are prescribed by a health care provider, including:

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

21 B. ~~Nothing in~~ Subsection A of this section DOES NOT:

- 22 1. ~~Entitles~~ ENTITLE a member or enrollee of an accountable health
23 plan to equipment or supplies for the treatment of diabetes that are not
24 medically necessary as determined by the accountable health plan's medical
25 director or the medical director's designee.
- 26 2. ~~Provides~~ PROVIDE coverage for diabetic supplies obtained by a
27 member or enrollee of an accountable health plan without a prescription
28 unless otherwise ~~permitted~~ ALLOWED pursuant to the terms of the health
29 benefits plan.
- 30 3. ~~Prohibits~~ PROHIBIT an accountable health plan from imposing
31 deductibles, coinsurance or other cost sharing in relation to benefits for
32 equipment or supplies for the treatment of diabetes, EXCEPT THAT AN
33 ACCOUNTABLE HEALTH PLAN SHALL LIMIT THE TOTAL AMOUNT THAT A MEMBER OR
34 ENROLLEE MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN
35 \$35 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF
36 INSULIN REQUIRED TO FILL THE MEMBER'S OR ENROLLEE'S PRESCRIPTION. FOR THE
37 PURPOSES OF THIS PARAGRAPH, "PRESCRIPTION INSULIN DRUG" MEANS ANY
38 PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED
39 BY A HEALTH CARE PROFESSIONAL TO A MEMBER OR ENROLLEE TO TREAT THE
40 MEMBER'S OR ENROLLEE'S CONDITION, THAT CONTAINS INSULIN AND THAT IS USED
41 TO TREAT DIABETES.