SENATE BILL 1601

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1402, 20-1404 AND 30-651, ARIZONA REVISED STATUTES; RELATING TO MEDICAL INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)
Be it enacted by the Legislature of the State of Arizona:

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

    20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

    E. Any contract, except accidental death and dismemberment, applied for that provides family coverage, 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 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.

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

G. No A corporation may NOT cancel or refuse to renew any
subscriber's contract without giving notice of such cancellation or
nonrenewal to the subscriber under such contract. A notice by the
corporation to the subscriber of cancellation or nonrenewal of a
subscription contract shall be mailed to the named subscriber at least
forty-five days before the effective date of such cancellation or
nonrenewal. The notice shall include or be accompanied by a statement in
writing of the reasons for such action by the corporation. Failure of the
corporation to comply with this subsection shall invalidate any
cancellation or nonrenewal except a cancellation or nonrenewal for
nonpayment of premium.

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

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

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

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

2. DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER MODALITY AND AT SUCH AGE AND INTERVALS AS RECOMMENDED BY THE NATIONAL COMPREHENSIVE CANCER NETWORK. THIS INCLUDES PATIENTS AT RISK FOR BREAST CANCER WHO HAVE A FAMILY HISTORY WITH ONE OR MORE FIRST OR SECOND DEGREE RELATIVES WITH BREAST CANCER, PRIOR DIAGNOSIS OF BREAST CANCER, POSITIVE TESTING FOR HEREDITARY GENE MUTATIONS OR HETEROGENEOUSLY OR DENSE BREAST TISSUE BASED ON THE BREAST IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY.

J. Any contract that is issued to the insured and that provides 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 of the following are true:

1. The child is adopted within one year of birth.
2. The insured is legally obligated to pay the costs of birth.
3. All preexisting conditions and other limitations have been met by the insured.
4. 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.

K. The coverage prescribed by subsection J of this section 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.

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

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

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
7. Exceptions.
8. Reductions.
10. Requirements for replacement.
11. Any other condition of subscription contracts.

N. 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 corporation 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 corporation 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 O 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.

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

1. 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. Prevent a corporation 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 N of this section shall not be greater
than the coinsurance or cost sharing for any preceding portion of that stay.

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

P. 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:

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.

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

R. Any hospital or medical service 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 S of this section or medical literature that meets the criteria prescribed in subsection S 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. Notwithstanding section 20-841.05, 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. Notwithstanding section 20-841.05, 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.

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

1. The acceptable standard medical reference compendia are the following:
   (a) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.
   (b) The national comprehensive cancer network drugs and biologics compendium.
   (c) Thomson Micromedex compendium DrugDex.
   (d) Elsevier gold standard’s clinical pharmacology compendium.
   (e) Other authoritative compendia as identified by the secretary of the United States department of health and human services.

2. Medical literature may be accepted if all of the following apply:
   (a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
   (b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
   (c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal
specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

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

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

V. 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.

W. 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 as medically necessary for the
therapeutic treatment of an inherited metabolic disease.

X. A hospital service corporation or medical service corporation
shall cover at least fifty percent PERCENT of the cost of medical foods
prescribed to treat inherited metabolic disorders and covered pursuant to
this section. A hospital service corporation or medical service
corporation 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.

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

1. If the contract provides coverage for prescription drugs, the
contract shall 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 corporation 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. The corporation 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. If the contract provides coverage for outpatient health care
services, the contract shall 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.

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

Z. Notwithstanding subsection Y of this section, a religiously
affiliated employer may require that the corporation provide a contract
without coverage for specific items or services required under subsection
Y 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 Y of this section, a written affidavit shall be
filed with the corporation stating the objection. On receipt of the affidavit, the corporation shall issue to the religiously affiliated employer a contract that excludes coverage for specific items or services required under subsection Y of this section. The corporation shall retain the affidavit for the duration of the contract and any renewals of the contract. This subsection shall not exclude coverage for prescription contraceptive methods ordered by a health care provider with prescriptive authority for medical indications other than for contraceptive, abortifacient, abortion or sterilization purposes. A religiously affiliated employer offering the plan may state religious beliefs in its affidavit and may require the subscriber to first pay for the prescription and then submit a claim to the hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation along with evidence that the prescription is not for a purpose covered by the objection. A hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation may charge an administrative fee for handling these claims.

AA. Subsection Z 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.

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

CC. 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 enteraly under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.
      (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.
   (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.
   (iv) Essential to a person's optimal growth, health and metabolic homeostasis.

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

3. Subsections Z and AA 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 primarily serves 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. 2. Section 20-1057, Arizona Revised Statutes, is amended to read:

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

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

B. Any contract, except accidental death and dismemberment, applied for that provides family coverage shall also provide, as to such coverage of family members, that the benefits applicable for children shall be payable with respect to a newly born child of the enrollee from the instant of such child's birth, to a child adopted by the enrollee, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the enrollee 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 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 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 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
disapproval within fifteen days after a request for a hearing in writing is received from the health care services organization. 

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

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

J. A contract that provides coverage for surgical services for a mastectomy shall also provide coverage for PREVENTIVE mammography screening AND DIAGNOSTIC IMAGING performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines, INCLUDING:
1. A baseline mammogram for a woman from age thirty-five to thirty-nine.

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

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

2. DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER MODALITY AND AT SUCH AGE AND INTERVALS AS RECOMMENDED BY THE NATIONAL COMPREHENSIVE CANCER NETWORK. THIS INCLUDES PATIENTS AT RISK FOR BREAST CANCER WHO HAVE A FAMILY HISTORY WITH ONE OR MORE FIRST OR SECOND DEGREE RELATIVES WITH BREAST CANCER, PRIOR DIAGNOSIS OF BREAST CANCER, POSITIVE TESTING FOR HEREDITARY GENE MUTATIONS OR HETEROGENEOUSLY OR DENSE BREAST TISSUE BASED ON THE BREAST IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY.

K. Any contract that is issued to the enrollee and that provides 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 enrollee if all the following are true:

1. The child is adopted within one year of birth.
2. The enrollee is legally obligated to pay the costs of birth.
3. All preexisting conditions and other limitations have been met and all deductibles and copayments have been paid by the enrollee.
4. The enrollee has notified the insurer of the enrollee'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.

L. The coverage prescribed by subsection K of this section 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. 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 enrollee adopting parents shall notify their health care services organization of the existence and extent of the other coverage. A health care services organization is not required to pay any costs in excess of the amounts it would have been obligated to pay to its hospitals and providers if the natural mother and child had received the maternity and newborn care directly from or through that health care services organization.

M. Each health care services organization shall offer membership to the following in a conversion plan that provides the basic health care benefits required by the director:
1. Each enrollee including the enrollee's enrolled dependents leaving a group.

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

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

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

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

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

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

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

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

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

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

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

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

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
7. Exceptions.
8. Reductions.
10. Requirements for replacement.
11. Any other conditions of evidences of coverage.

R. 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 health care services organization 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 health care services organization 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 S 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.

5. **Nothing** in Subsection R of this section **DOES NOT:**

1. Requires 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 a health care services organization 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 R of this section shall not be
greater than the coinsurance or cost sharing for any preceding portion of
that stay.

3. Prevents 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:

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 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.

V. Any contract or evidence of coverage 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 W of this section or medical literature that meets the criteria prescribed in subsection W 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. Notwithstanding section 20-1057.02, 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 or evidence of coverage.

5. Notwithstanding section 20-1057.02, prohibit a contract or evidence of coverage 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.

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

1. The acceptable standard medical reference compendia are the following:
(a) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.
(b) The national comprehensive cancer network drugs and biologics compendium.
(c) Thomson Micromedex compendium DrugDex.
(d) Elsevier gold standard’s clinical pharmacology compendium.
(e) Other authoritative compendia as identified by the secretary of the United States department of health and human services.

2. Medical literature may be accepted if all of the following apply:
(a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
(b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

X. A health care services organization shall not issue or deliver any advertising matter or sales material to any person in this state until the health care services organization files the advertising matter or sales material with the director. This subsection does not require a health care services organization to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the health care services organization to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At least five days before issuing an order pursuant to this subsection, the director shall provide the health care services organization with a written notice of the basis of the order to provide the health care services organization with an opportunity to cure the alleged deficiency in the advertising matter or sales material within a single five-day period for the particular advertising matter or sales material at issue. The health care services organization
services organization may appeal the director's order pursuant to title 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:
   (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.
      (iv) Essential to a person's optimal growth, health and metabolic homeostasis.

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

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

20-1342. Scope and format of policy; definitions
A. A policy of disability insurance shall not be delivered or issued for delivery to any person in this state unless it otherwise complies with this title and complies with the following:
1. The entire money and other considerations shall be expressed in 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 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.
6. Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page.

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

8. Each contract shall be so written that the corporation shall pay benefits:
   (a) For performance of any surgical service that is covered by the terms of such contract, regardless of the place of service.
   (b) For any home health services that are performed by a licensed home health agency and that a physician has prescribed in lieu of hospital services, as defined by the director, providing the hospital services would have been covered.
   (c) For any diagnostic service that a physician has performed outside a hospital in lieu of inpatient service, providing the inpatient service would have been covered.
   (d) For any service performed in a hospital's outpatient department or in a freestanding surgical facility, providing such service would have been covered if performed as an inpatient service.

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

10. A contract, except a supplemental contract covering a specified disease or other limited benefits, that provides coverage for surgical services for a mastectomy shall also provide coverage for PREVENTIVE mammography screening AND DIAGNOSTIC IMAGING performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines, INCLUDING:
   (a) A baseline mammogram for a woman from age thirty-five to thirty-nine.
   (b) A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's physician.
   (c) A mammogram every year for a woman fifty years of age and over.
(b) DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER MODALITY AND AT SUCH AGE AND INTERVALS AS RECOMMENDED BY THE NATIONAL COMPREHENSIVE CANCER NETWORK. THIS INCLUDES PATIENTS AT RISK FOR BREAST CANCER WHO HAVE A FAMILY HISTORY WITH ONE OR MORE FIRST OR SECOND DEGREE RELATIVES WITH BREAST CANCER, PRIOR DIAGNOSIS OF BREAST CANCER, POSITIVE TESTING FOR HEREDITARY GENE MUTATIONS OR HETEROGENEOUSLY OR DENSE BREAST TISSUE BASED ON THE BREAST IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY.

11. Any contract that is issued to the insured and that provides 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 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 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 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:

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

20-1402. Provisions of group disability policies; definitions
A. Each group disability policy shall contain in substance the following provisions:
  1. A provision that in the absence of fraud, all statements made by the policyholder or by any insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or beneficiary.
  2. A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of the employee or member and to whom benefits are payable. If dependents or family members are included in the coverage additional certificates need not be issued for delivery to the dependents or family members. Any policy, except accidental death and dismemberment, applied for that provides family coverage, 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 the 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 such thirty-one day period.
3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

4. Each contract shall be so written that the corporation shall pay benefits:
   (a) For performance of any surgical service that is covered by the terms of such contract, regardless of the place of service.
   (b) For any home health services that are performed by a licensed home health agency and that a physician has prescribed in lieu of hospital services, as defined by the director, providing the hospital services would have been covered.
   (c) For any diagnostic service that a physician has performed outside a hospital in lieu of inpatient service, providing the inpatient service would have been covered.
   (d) For any service performed in a hospital's outpatient department or in a freestanding surgical facility, providing such service would have been covered if performed as an inpatient service.

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

6. A contract, except a supplemental contract covering a specified disease or other limited benefits, that provides coverage for surgical services for a mastectomy shall also provide coverage for PREVENTIVE mammography screening AND DIAGNOSTIC IMAGING performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines, INCLUDING:
   (a) A baseline mammogram for a woman from age thirty-five to thirty-nine.
   (b) A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman’s physician.
   (c) A mammogram every year for a woman fifty years of age and over.
   (d) DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER MODALITY AND AT SUCH AGE AND INTERVALS AS RECOMMENDED BY THE NATIONAL COMPREHENSIVE CANCER NETWORK. THIS INCLUDES PATIENTS AT RISK FOR BREAST CANCER WHO HAVE A FAMILY HISTORY WITH ONE OR MORE FIRST OR SECOND DEGREE RELATIVES WITH BREAST CANCER, PRIOR DIAGNOSIS OF BREAST CANCER, POSITIVE TESTING FOR HEREDITARY GENE MUTATIONS OR HETEROGENEOUSLY
7. Any contract that is issued to the insured and that provides 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.

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.

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 policy, 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:
   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 prohibits DOES NOT PROHIBIT a group disability insurer from imposing deductibles, coinsurance
or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes.

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:

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

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

   (c) Thomson Micromedex compendium DrugDex.

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

   (e) Other authoritative compendia as identified by the secretary of the United States department of health and human services.
2. Medical literature may be accepted if all of the following apply:
   (a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
   (b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
   (c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

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

I. 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.

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 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. 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. 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
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.

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

P. 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.

(iv) Essential to a person's optimal growth, health and metabolic
homeostasis.
2. Subsection A of this section, the term "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person 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.

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

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

E. Any policy or contract, except accidental death and dismemberment, applied for that provides family coverage, 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 or 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.

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

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

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

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

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

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

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

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

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

2. DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE IMAGING, ULTRASOUND OR OTHER MODALITY AND AT SUCH AGE AND INTERVALS AS RECOMMENDED BY THE NATIONAL COMPREHENSIVE CANCER NETWORK. THIS INCLUDES PATIENTS AT RISK FOR BREAST CANCER WHO HAVE A FAMILY HISTORY WITH ONE OR MORE FIRST OR SECOND DEGREE RELATIVES WITH BREAST CANCER, PRIOR DIAGNOSIS OF BREAST CANCER, POSITIVE TESTING FOR HEREDITARY GENE MUTATIONS OR HETEROGENEOUSLY OR DENSE BREAST TISSUE BASED ON THE BREAST IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY.

I. Any contract that is issued to the insured and that provides 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:

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

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

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

4. The insured has notified the insurer of his 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.

J. The coverage prescribed by subsection I of this section 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. 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.

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 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:

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 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.

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.

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.

P. For the purposes of subsection O of this section:

1. The acceptable standard medical reference compendia are the following:
   (a) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.
   (b) The national comprehensive cancer network drugs and biologics compendium.
   (c) Thomson Micromedex compendium DrugDex.
   (d) Elsevier gold standard's clinical pharmacology compendium.
   (e) Other authoritative compendia as identified by the secretary of the United States department of health and human services.

2. Medical literature may be accepted if all of the following apply:
   (a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
   (b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
   (c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal.
specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

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

R. 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.
   5. 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.
   6. An insurer 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 insurer 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.
   7. Any blanket 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 blanket disability insurer may use a drug formulary, multited drug formulary or list but that formulary or list shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods. The blanket disability insurer does 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.

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.

(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.

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

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

3. Subsections V and W 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. 6. Section 30-651, Arizona Revised Statutes, is amended to read:

30-651. Definitions

In this chapter, unless the context otherwise requires:

1. "Atomic energy" means all forms of energy released in the course of nuclear transformations, nuclear fission and nuclear fusion.

2. "By-product material" means any radioactive material, except special nuclear material, yielded in or made radioactive by exposure to the radiation incident to the process of producing or utilizing special nuclear material and the tailings or wastes produced by the extraction or concentration of uranium ore thorium from any ore processed primarily for its source material content.

3. "Department" means the department of health services.

4. "Diagnostic mammography" means an x-ray imaging of the breast performed on persons who have symptoms or physical signs indicative of breast disease.

5. "DIGITAL BREAST TOMOSYNTHESIS" MEANS MULTIPLE LOW DOSE IMAGES OF THE BREAST AS AN X-RAY TUBE MOVES AROUND AN ARC. THE IMAGES ARE THEN RECONSTRUCTED TO PRODUCE A VOLUME RENDERING OF THE BREAST.

6. "Director" means the director of the department.

7. "Electronic product" means:
   
   (a) Any machine or device designed to produce a beam of ionizing radiation as the result of the operation of an electronic circuit or component.

   (b) Class IIIb and IV lasers, as classified by the United States food and drug administration.

   (c) Radio frequency heaters, dryers and sealers.

   (d) Any device employing a source of radio frequency electromagnetic radiation within a protective enclosure and used for heating or curing materials in industrial or manufacturing applications and in restaurants or food vending establishments. This subdivision does not include microwave ovens manufactured as consumer products and used for home food preparation.

   (e) Microwave and shortwave diathermy.

   (f) Mercury vapor, metal halide and high-pressure sodium lamps used for commercial lighting and industrial manufacturing processes or sunlamps used in commercial establishments for the intentional irradiation of humans.

   (g) Therapeutic ultrasound devices.

   (h) Industrial ultrasonic welders and sealers.

8. "Electronic product radiation" means:

   (a) Any ionizing or nonionizing electromagnetic or particulate radiation that is emitted from an electronic product.
(b) Any sonic, infrasonic or ultrasonic wave that is emitted from an electronic product as the result of the operation of an electronic circuit in the product.

9. "Ionizing radiation" means gamma rays and x-rays, alpha and beta particles, high speed electrons, neutrons, protons and other nuclear particles or rays.

10. "Operation" means adjustments or procedures by the user required for the equipment to perform its intended functions.

11. "Person" means any individual, corporation, partnership, firm, association, trust, estate, public or private institution, group, agency or political subdivision of this state, or any other state or political subdivision or agency of such state, and any legal successor, representative, agent, or agency of the foregoing, other than the United States nuclear regulatory commission or any successor, and other than federal government agencies and any other entities licensed by the United States nuclear regulatory commission or any successor.

12. "Radiation" means:
   (a) Ionizing radiation, including gamma rays, x-rays, alpha and beta particles, high speed electrons, neutrons, protons and other nuclear particles or rays.
   (b) Any electromagnetic radiation that may be produced by the operation of an electronic product.
   (c) Any sonic, ultrasonic or infrasonic wave that may be produced by the operation of an electronic product.

13. "Radiation machine" means any manufactured devices or products producing any of the following:
   (a) X-rays for medical, industrial, research and development or educational purposes.
   (b) Electromagnetic radiation from an electronic product.
   (c) Laser devices classified as class IIIb or IV by the United States food and drug administration.
   (d) Diathermy machines.

14. "Radioactive material" means any material or materials, solid, liquid or gaseous, that emit radiation spontaneously.

15. "Screening mammography":
   (a) Means x-ray imaging of the breast of asymptomatic persons.
   (b) INCLUDES DIGITAL BREAST TOMOSYNTHESIS.

16. "Service" means major adjustments or repairs, usually requiring specialized training or tools, or both.

17. "Source material" means:
   (a) Uranium, thorium or any other material that the governor declares by order to be source material after the United States nuclear regulatory commission or any successor has determined the material to be source material.
(b) Ores containing one or more of the materials, as provided in subdivision (a) of this paragraph, in such a concentration as the governor declares by order to be source material after the United States nuclear regulatory commission or any successor has determined the material in such a concentration to be source material.

“Sources of radiation” means radioactive materials, radiation machines and electronic products.

“Special nuclear material”:

(a) Means:

(i) Plutonium, uranium 233, uranium enriched in the isotope 233 or in the isotope 235 and any other material that the governor declares by order to be special nuclear material after the United States nuclear regulatory commission or any successor has determined the material to be special nuclear material but does not include source material.

(ii) Any material artificially enriched by any of the material provided in subdivision (a) ITEM (i) of this paragraph but does not include source material.

(b) Does not include source material.