

REFERENCE TITLE: breast examinations; cancer screenings; age

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

SB 1601

Introduced by
Senators Shamp; Kaiser; Representative Smith

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)

1 Be it enacted by the Legislature of the State of Arizona:

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

4 20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

31 E. Any contract, except accidental death and dismemberment, applied
32 for that provides family coverage, as to such coverage of family members,
33 shall also provide that the benefits applicable for children shall be
34 payable with respect to a newly born child of the insured from the instant
35 of such child's birth, to a child adopted by the insured, regardless of
36 the age at which the child was adopted, and to a child who has been placed
37 for adoption with the insured and for whom the application and approval
38 procedures for adoption pursuant to section 8-105 or 8-108 have been
39 completed to the same extent that such coverage applies to other members
40 of the family. The coverage for newly born or adopted children or
41 children placed for adoption shall include coverage of injury or sickness,
42 including necessary care and treatment of medically diagnosed congenital
43 defects and birth abnormalities. If payment of a specific premium is
44 required to provide coverage for a child, the contract may require that
45 notification of birth, adoption or adoption placement of the child and

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

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

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

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

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

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

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

4 ~~3.~~ 2. A mammogram, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC
5 RESONANCE IMAGING OR ULTRASOUND every year for a woman ~~fifty~~ WHO IS FORTY
6 years of age and over.

7 3. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
8 IMAGING OR ULTRASOUND AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
9 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

10 4. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
11 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF:

12 (a) A SCREENING MAMMOGRAM REVEALS ANY ABNORMALITY WHERE AN
13 ADDITIONAL EXAMINATION IS DEEMED MEDICALLY NECESSARY BY THE RADIOLOGIST
14 INTERPRETING THE MAMMOGRAM.

15 (b) THE PATIENT PRESENTS WITH SYMPTOMS, INCLUDING A PALPABLE LUMP,
16 PAIN OR DISCHARGE.

17 (c) A HEALTH CARE PROVIDER DEEMS FURTHER IMAGING IS MEDICALLY
18 NECESSARY BASED ON PRIOR DIAGNOSTIC IMAGING.

19 5. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
20 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF THE PATIENT:

21 (a) IS DEEMED TO BE AT AN INCREASED LIFETIME RISK FOR BREAST CANCER
22 AS DEFINED BY MEDICALLY ESTABLISHED RISK MODELS THAT EVALUATE A LIFETIME
23 RISK OF BREAST CANCER AS GREATER THAN TWENTY PERCENT.

24 (b) HAS ADDITIONAL RISK FACTORS FOR BREAST CANCER, INCLUDING FAMILY
25 HISTORY OR PRIOR HISTORY OF BREAST CANCER, POSITIVE GENETIC TESTING,
26 HETEROGENEOUSLY OR EXTREMELY DENSE BREAST TISSUE BASED ON THE BREAST
27 IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY OR
28 OTHER RISK FACTORS AS DETERMINED BY THE PATIENT'S HEALTH CARE PROVIDER.

29 6. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
30 IMAGING OR ULTRASOUND IF THE PATIENT HAS A HISTORY OF BREAST CANCER.

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

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

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

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

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

43 K. The coverage prescribed by subsection J of this section is
44 excess to any other coverage the natural mother may have for maternity
45 benefits except coverage made available to persons pursuant to title 36,

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

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

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

- 16 1. Conditions of eligibility.
- 17 2. Coverage of dependents.
- 18 3. Preexisting conditions.
- 19 4. Termination of insurance.
- 20 5. Probationary periods.
- 21 6. Limitations.
- 22 7. Exceptions.
- 23 8. Reductions.
- 24 9. Elimination periods.
- 25 10. Requirements for replacement.
- 26 11. Any other condition of subscription contracts.

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

- 37 1. Deny the mother or the newborn child eligibility or continued
38 eligibility to enroll or to renew coverage under the terms of the contract
39 solely for the purpose of avoiding the requirements of this subsection.
- 40 2. Provide monetary payments or rebates to mothers to encourage
41 those mothers to accept less than the minimum protections available
42 pursuant to this subsection.
- 43 3. Penalize or otherwise reduce or limit the reimbursement of an
44 attending provider because that provider provided care to any insured
45 under the contract in accordance with this subsection.

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

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

8 0. ~~Nothing in~~ Subsection N of this section **DOES NOT**:

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

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

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

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

26 1. Blood glucose monitors.

27 2. Blood glucose monitors for the legally blind.

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

30 4. Insulin preparations and glucagon.

31 5. Insulin cartridges.

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

33 7. Injection aids.

34 8. Insulin cartridges for the legally blind.

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

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

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

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

44 Q. ~~Nothing in~~ Subsection P of this section ~~prohibits~~ **DOES NOT**
45 **PROHIBIT** a medical service corporation, a hospital service corporation or

1 a hospital, medical, dental and optometric service corporation from
2 imposing deductibles, coinsurance or other cost sharing in relation to
3 benefits for equipment or supplies for the treatment of diabetes.

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

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

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

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

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

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

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

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

38 1. The acceptable standard medical reference compendia are the
39 following:

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

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

44 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

21 T. A corporation shall not issue or deliver any advertising matter
22 or sales material to any person in this state until the corporation files
23 the advertising matter or sales material with the director. This
24 subsection does not require a corporation to have the prior approval of
25 the director to issue or deliver the advertising matter or sales material.
26 If the director finds that the advertising matter or sales material, in
27 whole or in part, is false, deceptive or misleading, the director may
28 issue an order disapproving the advertising matter or sales material,
29 directing the corporation to cease and desist from issuing, circulating,
30 displaying or using the advertising matter or sales material within a
31 period of time specified by the director but not less than ten days and
32 imposing any penalties prescribed in this title. At least five days
33 before issuing an order pursuant to this subsection, the director shall
34 provide the corporation with a written notice of the basis of the order to
35 provide the corporation with an opportunity to cure the alleged deficiency
36 in the advertising matter or sales material within a single ~~five-day~~
37 FIVE-DAY period for the particular advertising matter or sales material at
38 issue. The corporation may appeal the director's order pursuant to title
39 41, chapter 6, article 10. Except as otherwise provided in this
40 subsection, a corporation may obtain a stay of the effectiveness of the
41 order as prescribed in section 20-162. If the director certifies in the
42 order and provides a detailed explanation of the reasons in support of the
43 certification that continued use of the advertising matter or sales
44 material poses a threat to the health, safety or welfare of the public,
45 the order may be entered immediately without opportunity for cure and the

1 effectiveness of the order is not stayed pending the hearing on the notice
2 of appeal but the hearing shall be promptly instituted and determined.

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

7 V. The metabolic disorders triggering medical foods coverage under
8 this section shall:

9 1. Be part of the newborn screening program prescribed in section
10 36-694.

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

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

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

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

25 X. A hospital service corporation or medical service corporation
26 shall cover at least fifty ~~per cent~~ PERCENT of the cost of medical foods
27 prescribed to treat inherited metabolic disorders and covered pursuant to
28 this section. A hospital service corporation or medical service
29 corporation may limit the maximum annual benefit for medical foods under
30 this section to ~~five thousand dollars~~ \$5,000, which applies to the cost of
31 all prescribed modified low protein foods and metabolic formula.

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

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

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

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

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

35 AA. Subsection Z of this section does not authorize a religiously
36 affiliated employer to obtain an employee's protected health information
37 or to violate the health insurance portability and accountability act of
38 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
39 pursuant to that act.

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

1 CC. For the purposes of:

2 1. This section:

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

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

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

9 (i) Formulated to be consumed or administered enterally under the
10 supervision of a physician who is licensed pursuant to title 32, chapter
11 13 or 17.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 20-1057. Evidence of coverage by health care services
10 organizations; renewability; definitions

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

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

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

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

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

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

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

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

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

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

13 G. The director shall approve any form of evidence of coverage if
14 the requirements of subsections E and F of this section are met. It is
15 unlawful to issue such form until approved. If the director does not
16 disapprove any such form within forty-five days after the filing of the
17 form, it is deemed approved. If the director disapproves a form of
18 evidence of coverage, the director shall notify the health care services
19 organization. In the notice, the director shall specify the reasons for
20 the director's disapproval. The director shall grant a hearing on such
21 disapproval within fifteen days after a request for a hearing in writing
22 is received from the health care services organization.

23 H. A health care services organization shall not cancel or refuse
24 to renew an enrollee's evidence of coverage that was issued on a group
25 basis without giving notice of the cancellation or nonrenewal to the
26 enrollee and, on request of the director, to the department of insurance
27 and financial institutions. A notice by the organization to the enrollee
28 of cancellation or nonrenewal of the enrollee's evidence of coverage shall
29 be mailed to the enrollee at least sixty days before the effective date of
30 such cancellation or nonrenewal. The notice shall include or be
31 accompanied by a statement in writing of the reasons as stated in the
32 contract for such action by the organization. Failure of the organization
33 to comply with this subsection shall invalidate any cancellation or
34 nonrenewal except a cancellation or nonrenewal for nonpayment of premium,
35 for fraud or misrepresentation in the application or other enrollment
36 documents or for loss of eligibility as defined in the evidence of
37 coverage. A health care services organization shall not cancel an
38 enrollee's evidence of coverage issued on a group basis because of the
39 enrollee's or dependent's age, except for loss of eligibility as defined
40 in the evidence of coverage, sex, health status-related factor, national
41 origin or frequency of utilization of health care services of the
42 enrollee. An evidence of coverage issued on a group basis shall clearly
43 delineate all terms under which the health care services organization may
44 cancel or refuse to renew an evidence of coverage for an enrollee or
45 dependent. Nothing in this subsection prohibits the cancellation or

1 nonrenewal of a health benefits plan contract issued on a group basis for
2 any of the reasons allowed in section 20-2309. A health care services
3 organization may cancel or nonrenew an evidence of coverage issued to an
4 individual on a nongroup basis only for the reasons allowed by subsection
5 N of this section.

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

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

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

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

25 ~~3.~~ 2. A mammogram, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC
26 RESONANCE IMAGING OR ULTRASOUND every year for a woman ~~fifty~~ WHO IS FORTY
27 years of age and over.

28 3. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
29 IMAGING OR ULTRASOUND AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
30 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

31 4. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
32 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF:

33 (a) A SCREENING MAMMOGRAM REVEALS ANY ABNORMALITY WHERE AN
34 ADDITIONAL EXAMINATION IS DEEMED MEDICALLY NECESSARY BY THE RADIOLOGIST
35 INTERPRETING THE MAMMOGRAM.

36 (b) THE PATIENT PRESENTS WITH SYMPTOMS, INCLUDING A PALPABLE LUMP,
37 PAIN OR DISCHARGE.

38 (c) A HEALTH CARE PROVIDER DEEMS FURTHER IMAGING IS MEDICALLY
39 NECESSARY BASED ON PRIOR DIAGNOSTIC IMAGING.

40 5. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
41 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF THE PATIENT:

42 (a) IS DEEMED TO BE AT AN INCREASED LIFETIME RISK FOR BREAST CANCER
43 AS DEFINED BY MEDICALLY ESTABLISHED RISK MODELS THAT EVALUATE A LIFETIME
44 RISK OF BREAST CANCER AS GREATER THAN TWENTY PERCENT.

1 (b) HAS ADDITIONAL RISK FACTORS FOR BREAST CANCER, INCLUDING FAMILY
2 HISTORY OR PRIOR HISTORY OF BREAST CANCER, POSITIVE GENETIC TESTING,
3 HETEROGENEOUSLY OR EXTREMELY DENSE BREAST TISSUE BASED ON THE BREAST
4 IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY OR
5 OTHER RISK FACTORS AS DETERMINED BY THE PATIENT'S HEALTH CARE PROVIDER.

6 6. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
7 IMAGING OR ULTRASOUND IF THE PATIENT HAS A HISTORY OF BREAST CANCER.

8 K. Any contract that is issued to the enrollee and that provides
9 coverage for maternity benefits shall also provide that the maternity
10 benefits apply to the costs of the birth of any child legally adopted by
11 the enrollee if all the following are true:

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

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

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

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

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

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

38 1. Each enrollee including the enrollee's enrolled dependents
39 leaving a group.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 S. ~~Nothing in~~ Subsection R of this section DOES NOT:

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

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

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

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

- 20 1. Blood glucose monitors.
- 21 2. Blood glucose monitors for the legally blind.
- 22 3. Test strips for glucose monitors and visual reading and urine
23 testing strips.
- 24 4. Insulin preparations and glucagon.
- 25 5. Insulin cartridges.
- 26 6. Drawing up devices and monitors for the visually impaired.
- 27 7. Injection aids.
- 28 8. Insulin cartridges for the legally blind.
- 29 9. Syringes and lancets including automatic lancing devices.
- 30 10. Prescribed oral agents for controlling blood sugar that are
31 included on the plan formulary.

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

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

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

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

43 2. ~~Provides~~ PROVIDE coverage for diabetic supplies obtained by a
44 member or enrollee of a health care services organization without a

1 prescription unless otherwise allowed pursuant to the terms of the health
2 care plan.

3 3. ~~Prohibits~~ PROHIBIT a health care services organization from
4 imposing deductibles, coinsurance or other cost sharing in relation to
5 benefits for equipment or supplies for the treatment of diabetes.

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

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

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

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

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

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

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

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

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

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

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

3 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

16 1. Be part of the newborn screening program prescribed in section
17 36-694.

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

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

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

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

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

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

1 DD. For the purposes of:

2 1. This section:

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

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

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

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

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

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

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

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

23 (i) Formulated to be consumed or administered enterally under the
24 supervision of a physician who is licensed pursuant to title 32, chapter
25 13 or 17 or a registered nurse practitioner who is licensed pursuant to
26 title 32, chapter 15.

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

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

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

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

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

42 20-1342. Scope and format of policy; definitions

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

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

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

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

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

38 5. The exceptions and reductions of indemnity shall be set forth in
39 the policy and, other than those contained in sections 20-1345 through
40 20-1368, shall be printed and, at the insurer's option, either included
41 with the benefit provision to which they apply or under an appropriate
42 caption such as "exceptions", or "exceptions and reductions", except that
43 if an exception or reduction specifically applies only to a particular
44 benefit of the policy, a statement of such exception or reduction shall be
45 included with the benefit provision to which it applies.

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

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

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

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

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

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

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

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

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

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

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

1 ~~(c)~~ (b) A mammogram, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC
2 RESONANCE IMAGING OR ULTRASOUND every year for a woman ~~fifty~~ WHO IS FORTY
3 years of age and over.

4 (c) A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
5 IMAGING OR ULTRASOUND AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
6 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

7 (d) A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
8 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF:

9 (i) A SCREENING MAMMOGRAM REVEALS ANY ABNORMALITY WHERE AN
10 ADDITIONAL EXAMINATION IS DEEMED MEDICALLY NECESSARY BY THE RADIOLOGIST
11 INTERPRETING THE MAMMOGRAM.

12 (ii) THE PATIENT PRESENTS WITH SYMPTOMS, INCLUDING A PALPABLE LUMP,
13 PAIN OR DISCHARGE.

14 (iii) A HEALTH CARE PROVIDER DEEMS FURTHER IMAGING IS MEDICALLY
15 NECESSARY BASED ON PRIOR DIAGNOSTIC IMAGING.

16 (e) A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
17 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF THE PATIENT:

18 (i) IS DEEMED TO BE AT AN INCREASED LIFETIME RISK FOR BREAST CANCER
19 AS DEFINED BY MEDICALLY ESTABLISHED RISK MODELS THAT EVALUATE A LIFETIME
20 RISK OF BREAST CANCER AS GREATER THAN TWENTY PERCENT.

21 (ii) HAS ADDITIONAL RISK FACTORS FOR BREAST CANCER, INCLUDING
22 FAMILY HISTORY OR PRIOR HISTORY OF BREAST CANCER, POSITIVE GENETIC
23 TESTING, HETEROGENEOUSLY OR EXTREMELY DENSE BREAST TISSUE BASED ON THE
24 BREAST IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF
25 RADIOLOGY OR OTHER RISK FACTORS AS DETERMINED BY THE PATIENT'S HEALTH CARE
26 PROVIDER.

27 (f) A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
28 IMAGING OR ULTRASOUND IF THE PATIENT HAS A HISTORY OF BREAST CANCER.

29 11. Any contract that is issued to the insured and that provides
30 coverage for maternity benefits shall also provide that the maternity
31 benefits apply to the costs of the birth of any child legally adopted by
32 the insured if all the following are true:

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

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

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

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

41 12. The coverage prescribed by paragraph 11 of this subsection is
42 excess to any other coverage the natural mother may have for maternity
43 benefits except coverage made available to persons pursuant to title 36,
44 chapter 29, ~~but not including coverage made available to persons defined~~
45 ~~as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)~~

1 ~~and (e)~~. If such other coverage exists the agency, attorney or individual
2 arranging the adoption shall make arrangements for the insurance to pay
3 those costs that may be covered under that policy and shall advise the
4 adopting parent in writing of the existence and extent of the coverage
5 without disclosing any confidential information such as the identity of
6 the natural parent. The insured adopting parents shall notify their
7 insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 1. ~~Prohibits~~ PROHIBIT a disability insurer from imposing
27 deductibles, coinsurance or other cost sharing in relation to benefits for
28 equipment or supplies for the treatment of diabetes.

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

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

43 1. Require coverage of any prescription drug used in the treatment
44 of a type of cancer if the United States food and drug administration has

1 determined that the prescription drug is contraindicated for that type of
2 cancer.

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

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

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

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

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

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

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

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

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

26 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

41 (c) The literature meets the uniform requirements for manuscripts
42 submitted to biomedical journals established by the international
43 committee of medical journal editors or is published in a journal
44 specified by the United States department of health and human services as
45 acceptable peer reviewed medical literature pursuant to section

1 186(t)(2)(B) of the social security act (42 United States Code section
2 1395x(t)(2)(B)).

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

7 I. The metabolic disorders triggering medical foods coverage under
8 this section shall:

9 1. Be part of the newborn screening program prescribed in section
10 36-694.

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

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

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

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

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

32 L. For the purposes of:

33 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 20-1402. Provisions of group disability policies; definitions

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

31 1. A provision that, in the absence of fraud, all statements made
32 by the policyholder or by any insured person shall be deemed
33 representations and not warranties, and that no statement made for the
34 purpose of effecting insurance shall avoid such insurance or reduce
35 benefits unless contained in a written instrument signed by the
36 policyholder or the insured person, a copy of which has been furnished to
37 the policyholder or to the person or beneficiary.

38 2. A provision that the insurer will furnish to the policyholder,
39 for delivery to each employee or member of the insured group, an
40 individual certificate setting forth in summary form a statement of the
41 essential features of the insurance coverage of the employee or member and
42 to whom benefits are payable. If dependents or family members are
43 included in the coverage additional certificates need not be issued for
44 delivery to the dependents or family members. Any policy, except
45 accidental death and dismemberment, applied for that provides family

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

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

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

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

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

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

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

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

1 6. A contract, except a supplemental contract covering a specified
2 disease or other limited benefits, that provides coverage for surgical
3 services for a mastectomy shall also provide coverage for PREVENTATIVE
4 mammography screening AND DIAGNOSTIC IMAGING performed on dedicated
5 equipment for diagnostic purposes on referral by a patient's physician,
6 subject to all of the terms and conditions of the policy and according to
7 the following guidelines:

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

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

13 ~~(c)~~ (b) A mammogram, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC
14 RESONANCE IMAGING OR ULTRASOUND every year for a woman ~~fifty~~ WHO IS FORTY
15 years of age and over.

16 (c) A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
17 IMAGING OR ULTRASOUND AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
18 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

19 (d) A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
20 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF:

21 (i) A SCREENING MAMMOGRAM REVEALS ANY ABNORMALITY WHERE AN
22 ADDITIONAL EXAMINATION IS DEEMED MEDICALLY NECESSARY BY THE RADIOLOGIST
23 INTERPRETING THE MAMMOGRAM.

24 (ii) THE PATIENT PRESENTS WITH SYMPTOMS, INCLUDING A PALPABLE LUMP,
25 PAIN OR DISCHARGE.

26 (iii) A HEALTH CARE PROVIDER DEEMS FURTHER IMAGING IS MEDICALLY
27 NECESSARY BASED ON PRIOR DIAGNOSTIC IMAGING.

28 (e) A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
29 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF THE PATIENT:

30 (i) IS DEEMED TO BE AT AN INCREASED LIFETIME RISK FOR BREAST CANCER
31 AS DEFINED BY MEDICALLY ESTABLISHED RISK MODELS THAT EVALUATE A LIFETIME
32 RISK OF BREAST CANCER AS GREATER THAN TWENTY PERCENT.

33 (ii) HAS ADDITIONAL RISK FACTORS FOR BREAST CANCER, INCLUDING
34 FAMILY HISTORY OR PRIOR HISTORY OF BREAST CANCER, POSITIVE GENETIC
35 TESTING, HETEROGENEOUSLY OR EXTREMELY DENSE BREAST TISSUE BASED ON THE
36 BREAST IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF
37 RADIOLOGY OR OTHER RISK FACTORS AS DETERMINED BY THE PATIENT'S HEALTH CARE
38 PROVIDER.

39 (f) A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
40 IMAGING OR ULTRASOUND IF THE PATIENT HAS A HISTORY OF BREAST CANCER.

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

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

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

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

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

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

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

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

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

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

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

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

1 C. ~~Nothing in~~ Subsection B of this section **DOES NOT**:
2 1. ~~Requires~~ **REQUIRE** a mother to give birth in a hospital or to stay
3 in the hospital for a fixed period of time following the birth of the
4 child.
5 2. ~~Prevents~~ **PREVENT** an insurer from imposing deductibles,
6 coinsurance or other cost sharing in relation to benefits for hospital
7 lengths of stay in connection with childbirth for a mother or a newborn
8 child under the policy, except that any coinsurance or other cost sharing
9 for any portion of a period within a hospital length of stay required
10 pursuant to subsection B of this section shall not be greater than the
11 coinsurance or cost sharing for any preceding portion of that stay.
12 3. ~~Prevents~~ **PREVENT** an insurer from negotiating the level and type
13 of reimbursement with a provider for care provided in accordance with
14 subsection B of this section.
15 D. Any contract that provides coverage for diabetes shall also
16 provide coverage for equipment and supplies that are medically necessary
17 and that are prescribed by a health care provider including:
18 1. Blood glucose monitors.
19 2. Blood glucose monitors for the legally blind.
20 3. Test strips for glucose monitors and visual reading and urine
21 testing strips.
22 4. Insulin preparations and glucagon.
23 5. Insulin cartridges.
24 6. Drawing up devices and monitors for the visually impaired.
25 7. Injection aids.
26 8. Insulin cartridges for the legally blind.
27 9. Syringes and lancets including automatic lancing devices.
28 10. Prescribed oral agents for controlling blood sugar that are
29 included on the plan formulary.
30 11. To the extent coverage is required under medicare, podiatric
31 appliances for prevention of complications associated with diabetes.
32 12. Any other device, medication, equipment or supply for which
33 coverage is required under medicare from and after January 1, 1999. The
34 coverage required in this paragraph is effective six months after the
35 coverage is required under medicare.
36 E. ~~Nothing in~~ Subsection D of this section ~~prohibits~~ **DOES NOT**
37 **PROHIBIT** a group disability insurer from imposing deductibles, coinsurance
38 or other cost sharing in relation to benefits for equipment or supplies
39 for the treatment of diabetes.
40 F. Any contract that provides coverage for prescription drugs shall
41 not limit or exclude coverage for any prescription drug prescribed for the
42 treatment of cancer on the basis that the prescription drug has not been
43 approved by the United States food and drug administration for the
44 treatment of the specific type of cancer for which the prescription drug
45 has been prescribed, if the prescription drug has been recognized as safe

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

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

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

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

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

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

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

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

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

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

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

34 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 P. For the purposes of:

2 1. This section:

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

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

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

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

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

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

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

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

23 (i) Formulated to be consumed or administered enterally under the
24 supervision of a physician who is licensed pursuant to title 32, chapter
25 13 or 17 or a registered nurse practitioner who is licensed pursuant to
26 title 32, chapter 15.

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

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

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

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

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

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

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

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

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

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

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

11 20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

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

1 operations sponsored or supervised by or on the premises of the
2 policyholder.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43 G. A blanket disability insurance policy that provides coverage for
44 the surgical expense of a mastectomy shall also provide coverage
45 incidental to the patient's covered mastectomy for the expense of

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

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

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

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

18 ~~3.~~ 2. A mammogram, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC
19 RESONANCE IMAGING OR ULTRASOUND every year for a woman ~~fifty~~ WHO IS FORTY
20 years of age and over.

21 3. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
22 IMAGING OR ULTRASOUND AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
23 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

24 4. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
25 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF:

26 (a) A SCREENING MAMMOGRAM REVEALS ANY ABNORMALITY WHERE AN
27 ADDITIONAL EXAMINATION IS DEEMED MEDICALLY NECESSARY BY THE RADIOLOGIST
28 INTERPRETING THE MAMMOGRAM.

29 (b) THE PATIENT PRESENTS WITH SYMPTOMS, INCLUDING A PALPABLE LUMP,
30 PAIN OR DISCHARGE.

31 (c) A HEALTH CARE PROVIDER DEEMS FURTHER IMAGING IS MEDICALLY
32 NECESSARY BASED ON PRIOR DIAGNOSTIC IMAGING.

33 5. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
34 IMAGING OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS IF THE PATIENT:

35 (a) IS DEEMED TO BE AT AN INCREASED LIFETIME RISK FOR BREAST CANCER
36 AS DEFINED BY MEDICALLY ESTABLISHED RISK MODELS THAT EVALUATE A LIFETIME
37 RISK OF BREAST CANCER AS GREATER THAN TWENTY PERCENT.

38 (b) HAS ADDITIONAL RISK FACTORS FOR BREAST CANCER THAT INCLUDE
39 FAMILY HISTORY, PRIOR HISTORY OF BREAST CANCER, POSITIVE GENETIC TESTING,
40 HETEROGENEOUSLY OR EXTREMELY DENSE BREAST TISSUE BASED ON THE BREAST
41 IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY OR
42 OTHER RISK FACTORS AS DETERMINED BY THE PATIENT'S HEALTH CARE PROVIDER.

43 6. A MAMMOGRAM, DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE
44 IMAGING OR ULTRASOUND IF THE PATIENT HAS A HISTORY OF BREAST CANCER.

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

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

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

13 J. The coverage prescribed by subsection I of this section is
14 excess to any other coverage the natural mother may have for maternity
15 benefits except coverage made available to persons pursuant to title 36,
16 chapter 29. If such other coverage exists the agency, attorney or
17 individual arranging the adoption shall make arrangements for the
18 insurance to pay those costs that may be covered under that policy and
19 shall advise the adopting parent in writing of the existence and extent of
20 the coverage without disclosing any confidential information such as the
21 identity of the natural parent. The insured adopting parents shall notify
22 their insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

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

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

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

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

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

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

41 N. ~~Nothing in~~ Subsection M of this section ~~prohibits~~ **DOES NOT**
42 **PROHIBIT** a blanket disability insurer from imposing deductibles,
43 coinsurance or other cost sharing in relation to benefits for equipment or
44 supplies for the treatment of diabetes.

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

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

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

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

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

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

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

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

34 1. The acceptable standard medical reference compendia are the
35 following:

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

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

40 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

42 T. An insurer shall cover at least fifty percent of the cost of
43 medical foods prescribed to treat inherited metabolic disorders and
44 covered pursuant to this section. An insurer may limit the maximum annual
45 benefit for medical foods under this section to \$5,000, which applies to

1 the cost of all prescribed modified low protein foods and metabolic
2 formula.

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

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

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

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

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

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

9 Y. For the purposes of:

10 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 Sec. 6. Section 30-651, Arizona Revised Statutes, is amended to
19 read:

20 30-651. Definitions

21 In this chapter, unless the context otherwise requires:

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

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

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

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

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

37 ~~5.~~ 6. "Director" means the director of the department.

38 ~~6.~~ 7. "Electronic product" means:

39 (a) Any machine or device designed to produce a beam of ionizing
40 radiation as the result of the operation of an electronic circuit or
41 component.

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

44 (c) Radio frequency heaters, dryers and sealers.

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

7 (e) Microwave and shortwave diathermy.

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

12 (g) Therapeutic ultrasound devices.

13 (h) Industrial ultrasonic welders and sealers.

14 ~~7-~~ 8. "Electronic product radiation" means:

15 (a) Any ionizing or nonionizing electromagnetic or particulate
16 radiation that is emitted from an electronic product.

17 (b) Any sonic, infrasonic or ultrasonic wave that is emitted from
18 an electronic product as the result of the operation of an electronic
19 circuit in the product.

20 ~~8-~~ 9. "Ionizing radiation" means gamma rays and x-rays, alpha and
21 beta particles, high speed electrons, neutrons, protons and other nuclear
22 particles or rays.

23 ~~9-~~ 10. "Operation" means adjustments or procedures by the user
24 required for the equipment to perform its intended functions.

25 ~~10-~~ 11. "Person" means any individual, corporation, partnership,
26 firm, association, trust, estate, public or private institution, group,
27 agency or political subdivision of this state, or any other state or
28 political subdivision or agency of such state, and any legal successor,
29 representative, agent, or agency of the foregoing, other than the United
30 States nuclear regulatory commission or any successor, and other than
31 federal government agencies and any other entities licensed by the United
32 States nuclear regulatory commission or any successor.

33 ~~11-~~ 12. "Radiation" means:

34 (a) Ionizing radiation, including gamma rays, x-rays, alpha and
35 beta particles, high speed electrons, neutrons, protons and other nuclear
36 particles or rays.

37 (b) Any electromagnetic radiation that may be produced by the
38 operation of an electronic product.

39 (c) Any sonic, ultrasonic or infrasonic wave that may be produced
40 by the operation of an electronic product.

41 ~~12-~~ 13. "Radiation machine" means any manufactured devices or
42 products producing any of the following:

43 (a) X-rays for medical, industrial, research and development or
44 educational purposes.

45 (b) Electromagnetic radiation from an electronic product.

1 (c) Laser devices classified as class IIIb or IV by the United
2 States food and drug administration.

3 (d) Diathermy machines.

4 ~~13.~~ 14. "Radioactive material" means any material or materials,
5 solid, liquid or gaseous, that emit radiation spontaneously.

6 ~~14.~~ 15. "Screening mammography":

7 (a) Means x-ray imaging of the breast of asymptomatic persons.

8 (b) INCLUDES DIGITAL BREAST TOMOSYNTHESIS.

9 ~~15.~~ 16. "Service" means major adjustments or repairs, usually
10 requiring specialized training or tools, or both.

11 ~~16.~~ 17. "Source material" means:

12 (a) Uranium, thorium or any other material that the governor
13 declares by order to be source material after the United States nuclear
14 regulatory commission or any successor has determined the material to be
15 source material.

16 (b) Ores containing one or more of the materials, as provided in
17 subdivision (a) of this paragraph, in such a concentration as the governor
18 declares by order to be source material after the United States nuclear
19 regulatory commission or any successor has determined the material in such
20 a concentration to be source material.

21 ~~17.~~ 18. "Sources of radiation" means radioactive materials,
22 radiation machines and electronic products.

23 ~~18.~~ 19. "Special nuclear material":

24 (a) Means:

25 ~~(a)~~ (i) Plutonium, uranium 233, uranium enriched in the isotope
26 233 or in the isotope 235 and any other material that the governor
27 declares by order to be special nuclear material after the United States
28 nuclear regulatory commission or any successor has determined the material
29 to be special nuclear material, ~~but does not include source material.~~

30 ~~(b)~~ (ii) Any material artificially enriched by any of the material
31 provided in ~~subdivision (a)~~ ITEM (i) of this ~~paragraph~~ SUBDIVISION. ~~, but~~

32 (b) Does not include source material.