

Senate Engrossed

breast examinations; cancer screenings; age

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

SENATE BILL 1601

AN ACT

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

(TEXT OF BILL BEGINS ON NEXT PAGE)

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 PREVENTIVE 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, INCLUDING:~~

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

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

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

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

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

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

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

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

- 43 1. Conditions of eligibility.
44 2. Coverage of dependents.
45 3. Preexisting conditions.

1 4. Termination of insurance.

2 5. Probationary periods.

3 6. Limitations.

4 7. Exceptions.

5 8. Reductions.

6 9. Elimination periods.

7 10. Requirements for replacement.

8 11. Any other condition of subscription contracts.

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

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

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

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

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

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

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

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

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

1 than the coinsurance or cost sharing for any preceding portion of that
2 stay.

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

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

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

27 Q. ~~Nothing in~~ Subsection P of this section ~~prohibits~~ DOES NOT
28 PROHIBIT a medical service corporation, a hospital service corporation or
29 a hospital, medical, dental and optometric service corporation from
30 imposing deductibles, coinsurance or other cost sharing in relation to
31 benefits for equipment or supplies for the treatment of diabetes.

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

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

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

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

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

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

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

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

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

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

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

28 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 CC. For the purposes of:

27 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 1. The reservist shall make written application to the health plan
45 within ninety days of discharge from active military duty or within one

1 year of hospitalization continuing after discharge. Coverage shall be
2 effective on receipt of the application by the health plan.

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

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

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

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

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

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

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

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

44 5. Except as described in subsection S of this section, restrict
45 benefits for any portion of a period within the minimum length of stay in

1 a manner that is less favorable than the benefits provided for any
2 preceding portion of that stay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 1. The acceptable standard medical reference compendia are the
45 following:

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

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

5 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

1 services organization may appeal the director's order pursuant to title
2 41, chapter 6, article 10. Except as otherwise provided in this
3 subsection, a health care services organization may obtain a stay of the
4 effectiveness of the order as prescribed in section 20-162. If the
5 director certifies in the order and provides a detailed explanation of the
6 reasons in support of the certification that continued use of the
7 advertising matter or sales material poses a threat to the health, safety
8 or welfare of the public, the order may be entered immediately without
9 opportunity for cure and the effectiveness of the order is not stayed
10 pending the hearing on the notice of appeal but the hearing shall be
11 promptly instituted and determined.

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

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

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

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

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

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

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

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

41 CC. Unless preempted under federal law or unless federal law
42 imposes greater requirements than this section, this section applies to a
43 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 PREVENTIVE
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, INCLUDING:~~

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.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 1. Blood glucose monitors.

33 2. Blood glucose monitors for the legally blind.

34 3. Test strips for glucose monitors and visual reading and urine
35 testing strips.

36 4. Insulin preparations and glucagon.

37 5. Insulin cartridges.

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

39 7. Injection aids.

40 8. Insulin cartridges for the legally blind.

41 9. Syringes and lancets including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 1. The acceptable standard medical reference compendia are the
45 following:

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

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

5 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 L. For the purposes of:

13 1. This section:

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

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

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

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

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

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

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

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

34 (i) Formulated to be consumed or administered enterally under the
35 supervision of a physician who is licensed pursuant to title 32, chapter
36 13 or 17 or a registered nurse practitioner who is licensed pursuant to
37 title 32, chapter 15.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40 (b) DIGITAL BREAST TOMOSYNTHESIS, MAGNETIC RESONANCE IMAGING,
41 ULTRASOUND OR OTHER MODALITY AND AT SUCH AGE AND INTERVALS AS RECOMMENDED
42 BY THE NATIONAL COMPREHENSIVE CANCER NETWORK. THIS INCLUDES PATIENTS AT
43 RISK FOR BREAST CANCER WHO HAVE A FAMILY HISTORY WITH ONE OR MORE FIRST OR
44 SECOND DEGREE RELATIVES WITH BREAST CANCER, PRIOR DIAGNOSIS OF BREAST
45 CANCER, POSITIVE TESTING FOR HEREDITARY GENE MUTATIONS OR HETEROGENEOUSLY

1 OR DENSE BREAST TISSUE BASED ON THE BREAST IMAGING REPORTING AND DATA
2 SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY.

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

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

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

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

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

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

27 B. Any policy 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 policy shall not require the provider to obtain authorization from the
32 insurer for prescribing the minimum length of stay required by this
33 subsection. The policy 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 insurer 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 policy
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 policy 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 policy in a
3 manner that is inconsistent with this subsection.

4 5. Except as described in subsection C 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 C. ~~Nothing in~~ Subsection B 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** an insurer 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 policy, except that any coinsurance or other cost sharing
16 for any portion of a period within a hospital length of stay required
17 pursuant to subsection B of this section shall not be greater than the
18 coinsurance or cost sharing for any preceding portion of that stay.

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

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

25 1. Blood glucose monitors.

26 2. Blood glucose monitors for the legally blind.

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

29 4. Insulin preparations and glucagon.

30 5. Insulin cartridges.

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

32 7. Injection aids.

33 8. Insulin cartridges for the legally blind.

34 9. Syringes and lancets including automatic lancing devices.

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

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

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

43 E. ~~Nothing in~~ Subsection D of this section ~~prohibits~~ **DOES NOT**
44 **PROHIBIT** a group disability insurer from imposing deductibles, coinsurance

1 or other cost sharing in relation to benefits for equipment or supplies
2 for the treatment of diabetes.

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

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

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

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

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

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

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

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

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

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

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

42 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 L. Any group 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 group 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 group disability insurer ~~does~~ MAY not impose deductibles,
11 coinsurance, copayments or other cost containment measures for
12 contraceptive drugs that are greater than the deductibles, coinsurance,
13 copayments or other cost containment measures for other drugs on the same
14 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 M. Notwithstanding subsection L of this section, a religiously
22 affiliated employer may require that the insurer provide a group
23 disability policy without coverage for specific items or services required
24 under subsection L 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 L 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 group disability policy that excludes coverage for
32 specific items or services required under subsection L of this section.
33 The insurer shall retain the affidavit for the duration of the group
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.

1 N. Subsection M 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 O. Subsection M 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 P. 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 A 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 ~~the age of~~ eighteen years OF AGE.

5 3. Subsections M and N 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. 5. Section 20-1404, Arizona Revised Statutes, is amended to
19 read:

20 20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 4. The insured has notified the insurer of his acceptability to
45 adopt children pursuant to section 8-105, within sixty days after such

1 approval or within sixty days after a change in insurance policies, plans
2 or companies.

3 J. The coverage prescribed by subsection I of this section is
4 excess to any other coverage the natural mother may have for maternity
5 benefits except coverage made available to persons pursuant to title 36,
6 chapter 29. If such other coverage exists the agency, attorney or
7 individual arranging the adoption shall make arrangements for the
8 insurance to pay those costs that may be covered under that policy and
9 shall advise the adopting parent in writing of the existence and extent of
10 the coverage without disclosing any confidential information such as the
11 identity of the natural parent. The insured adopting parents shall notify
12 their insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

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

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

43 2. ~~Prevents~~ **PREVENT** an insurer from imposing deductibles,
44 coinsurance or other cost sharing in relation to benefits for hospital
45 lengths of stay in connection with childbirth for a mother or a newborn

1 child under the contract, except that any coinsurance or other cost
2 sharing for any portion of a period within a hospital length of stay
3 required pursuant to subsection K of this section shall not be greater
4 than the coinsurance or cost sharing for any preceding portion of that
5 stay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

9 R. The metabolic disorders triggering medical foods coverage under
10 this section shall:

11 1. Be part of the newborn screening program prescribed in section
12 36-694.

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

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

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

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

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

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

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

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

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

30 W. Subsection V of this section does not authorize a religiously
31 affiliated employer to obtain an employee's protected health information
32 or to violate the health insurance portability and accountability act of
33 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
34 pursuant to that act.

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

38 Y. For the purposes of:

39 1. This section:

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

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

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

2 (i) Formulated to be consumed or administered enterally under the
3 supervision of a physician who is licensed pursuant to title 32, chapter
4 13 or 17 or a registered nurse practitioner who is licensed pursuant to
5 title 32, chapter 15.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 30-651. Definitions

4 In this chapter, unless the context otherwise requires:

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

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

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

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

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

20 ~~5.~~ 6. "Director" means the director of the department.

21 ~~6.~~ 7. "Electronic product" means:

22 (a) Any machine or device designed to produce a beam of ionizing
23 radiation as the result of the operation of an electronic circuit or
24 component.

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

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

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

34 (e) Microwave and shortwave diathermy.

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

39 (g) Therapeutic ultrasound devices.

40 (h) Industrial ultrasonic welders and sealers.

41 ~~7.~~ 8. "Electronic product radiation" means:

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

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

4 ~~8.~~ 9. "Ionizing radiation" means gamma rays and x-rays, alpha and
5 beta particles, high speed electrons, neutrons, protons and other nuclear
6 particles or rays.

7 ~~9.~~ 10. "Operation" means adjustments or procedures by the user
8 required for the equipment to perform its intended functions.

9 ~~10.~~ 11. "Person" means any individual, corporation, partnership,
10 firm, association, trust, estate, public or private institution, group,
11 agency or political subdivision of this state, or any other state or
12 political subdivision or agency of such state, and any legal successor,
13 representative, agent, or agency of the foregoing, other than the United
14 States nuclear regulatory commission or any successor, and other than
15 federal government agencies and any other entities licensed by the United
16 States nuclear regulatory commission or any successor.

17 ~~11.~~ 12. "Radiation" means:

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

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

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

25 ~~12.~~ 13. "Radiation machine" means any manufactured devices or
26 products producing any of the following:

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

29 (b) Electromagnetic radiation from an electronic product.

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

32 (d) Diathermy machines.

33 ~~13.~~ 14. "Radioactive material" means any material or materials,
34 solid, liquid or gaseous, that emit radiation spontaneously.

35 ~~14.~~ 15. "Screening mammography":

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

37 (b) INCLUDES DIGITAL BREAST TOMOSYNTHESIS.

38 ~~15.~~ 16. "Service" means major adjustments or repairs, usually
39 requiring specialized training or tools, or both.

40 ~~16.~~ 17. "Source material" means:

41 (a) Uranium, thorium or any other material that the governor
42 declares by order to be source material after the United States nuclear
43 regulatory commission or any successor has determined the material to be
44 source material.

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

6 ~~17.~~ 18. "Sources of radiation" means radioactive materials,
7 radiation machines and electronic products.

8 ~~18.~~ 19. "Special nuclear material":

9 (a) Means:

10 ~~(a)~~ (i) Plutonium, uranium 233, uranium enriched in the isotope
11 233 or in the isotope 235 and any other material that the governor
12 declares by order to be special nuclear material after the United States
13 nuclear regulatory commission or any successor has determined the material
14 to be special nuclear material, ~~but does not include source material.~~

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

17 (b) Does not include source material.