

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

State of Arizona  
House of Representatives  
Fifty-seventh Legislature  
First Regular Session  
2025

# **HB 2820**

Introduced by  
Representative Stahl Hamilton

## AN ACT

AMENDING SECTIONS 20-826 AND 20-1057.08, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1376.11; AMENDING SECTIONS 20-1402 AND 20-1404, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:  
2 Section 1. Section 20-826, Arizona Revised Statutes, is amended to  
3 read:

4 **20-826. Subscription contracts; definitions**

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

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

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

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

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

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

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

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

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

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. A corporation may not cancel or refuse to renew any subscriber's  
19 contract without giving notice of such cancellation or nonrenewal to the  
20 subscriber under such contract. A notice by the corporation to the  
21 subscriber of cancellation or nonrenewal of a subscription contract shall  
22 be mailed to the named subscriber at least forty-five days before the  
23 effective date of such cancellation or nonrenewal. The notice shall  
24 include or be accompanied by a statement in writing of the reasons for  
25 such action by the corporation. Failure of the corporation to comply with  
26 this subsection shall invalidate any cancellation or nonrenewal except a  
27 cancellation or nonrenewal for nonpayment of premium.

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

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

41 1. A mammogram.  
42 2. Digital breast tomosynthesis, magnetic resonance imaging,  
43 ultrasound or other modality and at such age and intervals as recommended  
44 by the national comprehensive cancer network. This includes patients at  
45 risk for breast cancer who have a family history with one or more first or

1 second degree relatives with breast cancer, prior diagnosis of breast  
2 cancer, positive testing for hereditary gene mutations or heterogeneously  
3 or dense breast tissue based on the breast imaging reporting and data  
4 system of the American college of radiology.

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

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

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

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

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

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

- 33 1. Conditions of eligibility.
- 34 2. Coverage of dependents.
- 35 3. Preexisting conditions.
- 36 4. Termination of insurance.
- 37 5. Probationary periods.
- 38 6. Limitations.
- 39 7. Exceptions.
- 40 8. Reductions.
- 41 9. Elimination periods.
- 42 10. Requirements for replacement.
- 43 11. Any other condition of subscription contracts.

44 N. Any contract that provides maternity benefits shall not restrict  
45 benefits for any hospital length of stay in connection with childbirth for

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

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

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

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

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

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

25       O. Subsection N of this section does not:

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

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

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

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

41       1. Blood glucose monitors.

42       2. Blood glucose monitors for the legally blind.

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

45       4. Insulin preparations and glucagon.

1       5. Insulin cartridges.  
2       6. Drawing up devices and monitors for the visually impaired.  
3       7. Injection aids.  
4       8. Insulin cartridges for the legally blind.  
5       9. Syringes and lancets, including automatic lancing devices.  
6       10. Prescribed oral agents for controlling blood sugar that are  
7 included on the plan formulary.

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

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

14      Q. Subsection P of this section does not prohibit a medical service  
15 corporation, a hospital service corporation or a hospital, medical, dental  
16 and optometric service corporation from imposing deductibles, coinsurance  
17 or other cost sharing in relation to benefits for equipment or supplies  
18 for the treatment of diabetes.

19      R. Any hospital or medical service contract that provides coverage  
20 for prescription drugs shall not limit or exclude coverage for any  
21 prescription drug prescribed for the treatment of cancer on the basis that  
22 the prescription drug has not been approved by the United States food and  
23 drug administration for the treatment of the specific type of cancer for  
24 which the prescription drug has been prescribed, if the prescription drug  
25 has been recognized as safe and effective for treatment of that specific  
26 type of cancer in one or more of the standard medical reference compendia  
27 prescribed in subsection S of this section or medical literature that  
28 meets the criteria prescribed in subsection S of this section. The  
29 coverage required under this subsection includes covered medically  
30 necessary services associated with the administration of the prescription  
31 drug. This subsection does not:

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

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

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

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

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

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

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

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

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

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

15           (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

30           (c) The literature meets the uniform requirements for manuscripts  
31 submitted to biomedical journals established by the international  
32 committee of medical journal editors or is published in a journal  
33 specified by the United States department of health and human services as  
34 acceptable peer reviewed medical literature pursuant to section  
35 186(t)(2)(B) of the social security act (42 United States Code section  
36 1395x(t)(2)(B)).

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

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

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

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

41 X. A hospital service corporation or medical service corporation  
42 shall cover at least fifty percent of the cost of medical foods prescribed  
43 to treat inherited metabolic disorders and covered pursuant to this  
44 section. A hospital service corporation or medical service corporation  
45 may limit the maximum annual benefit for medical foods under this section

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

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

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

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

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

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

1 and then submit a claim to the hospital service corporation, medical  
2 service corporation or hospital, medical, dental and optometric service  
3 corporation along with evidence that the prescription is not for a purpose  
4 covered by the objection. A hospital service corporation, medical service  
5 corporation or hospital, medical, dental and optometric service  
6 corporation may charge an administrative fee for handling these claims.

7 AA. Subsection Z of this section does not authorize a religiously  
8 affiliated employer to obtain an employee's protected health information  
9 or to violate the health insurance portability and accountability act of  
10 1996 (P.L. 104-191, 110 Stat. 1936) or any federal regulations adopted  
11 pursuant to that act.

12 BB. Subsection Z of this section does not restrict or limit any  
13 protections against employment discrimination that are prescribed in  
14 federal or state law.

15 CC. Z. For the purposes of:

16 1. This section:

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

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

22 (c) "Metabolic formula" means foods that are all of the 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.

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

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

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

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

36 (i) Formulated to be consumed or administered enterally under the  
37 supervision of a physician who is licensed pursuant to title 32, chapter  
38 13 or 17.

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

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

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

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

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

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

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

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

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

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

Sec. 2. Section 20-1057.08, Arizona Revised Statutes, is amended to read:

20-1057-08. Prescription contraceptive drugs and devices

A. If a health care services organization issues evidence of coverage that provides coverage for:

1. Prescription drugs, the evidence of coverage shall provide coverage for any prescribed drug or device that is approved by the United States food and drug administration for use as a contraceptive. A health care services organization may use a drug formulary, multitiered drug formulary or list but that formulary or list shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods. ~~†† The health care services organization ~~does~~ ~~MAY~~ not impose deductibles, coinsurance, copayments or other cost containment measures for contraceptive drugs, ~~that are greater than the deductibles, coinsurance, copayments or other cost containment measures for other drugs on the same level of the formulary or list~~ INTRAUTERINE DEVICES, PRESCRIPTION BARRIER METHODS, OVER-THE-COUNTER CONTRACEPTION, CONTRACEPTIVE IMPLANTS, THERAPEUTIC EQUIVALENTS OR STERILIZATION.~~

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

1       B. Notwithstanding subsection A of this section, a religiously  
2 affiliated employer may require that the health care services organization  
3 provide an evidence of coverage without coverage for specific items or  
4 services required under subsection A of this section because providing or  
5 paying for coverage of the specific items or services is contrary to the  
6 religious beliefs of the religiously affiliated employer offering the  
7 plan. If a religiously affiliated employer objects to providing coverage  
8 for specific items or services required under subsection A of this  
9 section, a written affidavit shall be filed with the health care services  
10 organization stating the objection. On receipt of the affidavit, the  
11 health care services organization shall issue to the religiously  
12 affiliated employer an evidence of coverage that excludes coverage for  
13 specific items or services required under subsection A of this section.  
14 The health care services organization shall retain the affidavit for the  
15 duration of the coverage and any renewals of the coverage.

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

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

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

34       F. B. This section does not apply to evidences of coverage issued  
35 to individuals on a nongroup basis.

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

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

39       (a) The entity primarily employs persons who share the religious  
40 tenets of the entity.

41       (b) The entity serves primarily persons who share the religious  
42 tenets of the entity.

43       (c) The entity is a nonprofit organization as described in section  
44 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as  
45 amended.

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

Sec. 3. Title 20, chapter 6, article 4, Arizona Revised Statutes, is amended by adding section 20-1376.11, to read:

20-1376.11. Contraceptive coverage; prescriptions; male sterilization; cost sharing prohibited

A DISABILITY INSURANCE POLICY THAT INCLUDES PRESCRIPTION DRUG COVERAGE SHALL PROVIDE COVERAGE FOR ANY PRESCRIBED DRUG OR DEVICE THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION FOR USE AS A CONTRACEPTIVE. A DISABILITY INSURANCE POLICY MAY NOT INCLUDE ANY COST SHARING REQUIREMENTS FOR CONTRACEPTIVE DRUGS, INTRAUTERINE DEVICES, PRESCRIPTION BARRIER METHODS, OVER-THE-COUNTER CONTRACEPTION, CONTRACEPTIVE IMPLANTS, THERAPEUTIC EQUIVALENTS OR STERILIZATION.

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

## 20-1402. Provisions of group disability policies: definitions

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

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

2. A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of the employee or member and to whom benefits are payable. If dependents or family members are included in the coverage additional certificates need not be issued for delivery to the dependents or family members. Any policy, except accidental death and dismemberment, applied for that provides family coverage, as to such coverage of family members, shall also provide that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth, to a child adopted by the insured, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the insured and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth

1 abnormalities. If payment of a specific premium is required to provide  
2 coverage for a child, the policy may require that notification of birth,  
3 adoption or adoption placement of the child and payment of the required  
4 premium must be furnished to the insurer within thirty-one days after the  
5 date of birth, adoption or adoption placement in order to have the  
6 coverage continue beyond such thirty-one day period.

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

10 4. 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 5. A group disability insurance policy that provides coverage for  
25 the surgical expense of a mastectomy shall also provide coverage  
26 incidental to the patient's covered mastectomy for the expense of  
27 reconstructive surgery of the breast on which the mastectomy was  
28 performed, surgery and reconstruction of the other breast to produce a  
29 symmetrical appearance, prostheses, treatment of physical complications  
30 for all stages of the mastectomy, including lymphedemas, and at least two  
31 external postoperative prostheses subject to all of the terms and  
32 conditions of the policy.

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

39 (a) A mammogram.

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. If such other coverage exists the agency, attorney or  
19 individual arranging the adoption shall make arrangements for the  
20 insurance to pay those costs that may be covered under that policy and  
21 shall advise the adopting parent in writing of the existence and extent of  
22 the coverage without disclosing any confidential information such as the  
23 identity of the natural parent. The insured adopting parents shall notify  
24 their insurer of the existence and extent of the other coverage.

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

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

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

41 3. Penalize or otherwise reduce or limit the reimbursement of an  
42 attending provider because that provider provided care to any insured  
43 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. Subsection B of this section does not:

9       1. Require a mother to give birth in a hospital or to stay in the  
10 hospital for a fixed period of time following the birth of the child.

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

18       3. Prevent an insurer from negotiating the level and type of  
19 reimbursement with a provider for care provided in accordance with  
20 subsection B of this section.

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

24       1. Blood glucose monitors.

25       2. Blood glucose monitors for the legally blind.

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

28       4. Insulin preparations and glucagon.

29       5. Insulin cartridges.

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

31       7. Injection aids.

32       8. Insulin cartridges for the legally blind.

33       9. Syringes and lancets including automatic lancing devices.

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

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

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

42       E. Subsection D of this section does not prohibit a group  
43 disability insurer from imposing deductibles, coinsurance or other cost  
44 sharing in relation to benefits for equipment or supplies for the  
45 treatment of diabetes.

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

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

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

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

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

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

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

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

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

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

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

40       (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

1       L. Any group disability policy that provides coverage for:  
2       1. Prescription drugs shall also provide coverage for any  
3       prescribed drug or device that is approved by the United States food and  
4       drug administration for use as a contraceptive. A group disability  
5       insurer may use a drug formulary, multitiered drug formulary or list but  
6       that formulary or list shall include oral, implant and injectable  
7       contraceptive drugs, intrauterine devices and prescription barrier  
8       methods. The group disability insurer may not impose deductibles,  
9       coinsurance, copayments or other cost containment measures for  
10      contraceptive drugs, ~~that are greater than the deductibles, coinsurance,~~  
11      ~~copayments or other cost containment measures for other drugs on the same~~  
12      ~~level of the formulary or list~~ INTRAUTERINE DEVICES, PRESCRIPTION BARRIER  
13      METHODS, OVER-THE-COUNTER CONTRACEPTION, CONTRACEPTIVE IMPLANTS,  
14      THERAPEUTIC EQUIVALENTS OR STERILIZATION.

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       ~~religious 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.~~

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

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

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

7 ~~P.~~ M. For the purposes of:

8 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6       (iii) The entity serves primarily persons who share the religious  
7       tenets of the entity.

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

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

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

16      20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13      D. This section does not affect the legal liability of  
14 policyholders for the death of or injury to any member of the group.

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

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

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

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

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

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

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

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

18       1. A mammogram.

19       2. Digital breast tomosynthesis, magnetic resonance imaging,  
20 ultrasound or other modality and at such age and intervals as recommended  
21 by the national comprehensive cancer network. This includes patients at  
22 risk for breast cancer who have a family history with one or more first or  
23 second degree relatives with breast cancer, prior diagnosis of breast  
24 cancer, positive testing for hereditary gene mutations or heterogeneously  
25 or dense breast tissue based on the breast imaging reporting and data  
26 system of the American college of radiology.

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

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

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

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

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

39       J. The coverage prescribed by subsection I of this section is  
40 excess to any other coverage the natural mother may have for maternity  
41 benefits except coverage made available to persons pursuant to title 36,  
42 chapter 29. If such other coverage exists the agency, attorney or  
43 individual arranging the adoption shall make arrangements for the  
44 insurance to pay those costs that may be covered under that policy and  
45 shall advise the adopting parent in writing of the existence and extent of

1 the coverage without disclosing any confidential information such as the  
2 identity of the natural parent. The insured adopting parents shall notify  
3 their insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

30 L. Subsection K of this section does not:

31 1. Require a mother to give birth in a hospital or to stay in the  
32 hospital for a fixed period of time following the birth of the child.

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

40 3. Prevent an insurer from negotiating the level and type of  
41 reimbursement with a provider for care provided in accordance with  
42 subsection K of this section.

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

- 1       1. Blood glucose monitors.
- 2       2. Blood glucose monitors for the legally blind.
- 3       3. Test strips for glucose monitors and visual reading and urine
- 4       testing strips.
- 5       4. Insulin preparations and glucagon.
- 6       5. Insulin cartridges.
- 7       6. Drawing up devices and monitors for the visually impaired.
- 8       7. Injection aids.
- 9       8. Insulin cartridges for the legally blind.
- 10      9. Syringes and lancets including automatic lancing devices.
- 11      10. Prescribed oral agents for controlling blood sugar that are
- 12     included on the plan formulary.
- 13     11. To the extent coverage is required under medicare, podiatric
- 14    appliances for prevention of complications associated with diabetes.
- 15     12. Any other device, medication, equipment or supply for which
- 16    coverage is required under medicare from and after January 1, 1999. The
- 17    coverage required in this paragraph is effective six months after the
- 18    coverage is required under medicare.
- 19    N. Subsection M of this section does not prohibit a blanket
- 20    disability insurer from imposing deductibles, coinsurance or other cost
- 21    sharing in relation to benefits for equipment or supplies for the
- 22    treatment of diabetes.
- 23    O. Any contract that provides coverage for prescription drugs shall
- 24    not limit or exclude coverage for any prescription drug prescribed for the
- 25    treatment of cancer on the basis that the prescription drug has not been
- 26    approved by the United States food and drug administration for the
- 27    treatment of the specific type of cancer for which the prescription drug
- 28    has been prescribed, if the prescription drug has been recognized as safe
- 29    and effective for treatment of that specific type of cancer in one or more
- 30    of the standard medical reference compendia prescribed in subsection P of
- 31    this section or medical literature that meets the criteria prescribed in
- 32    subsection P of this section. The coverage required under this subsection
- 33    includes covered medically necessary services associated with the
- 34    administration of the prescription drug. This subsection does not:
- 35     1. Require coverage of any prescription drug used in the treatment
- 36    of a type of cancer if the United States food and drug administration has
- 37    determined that the prescription drug is contraindicated for that type of
- 38    cancer.
- 39     2. Require coverage for any experimental prescription drug that is
- 40    not approved for any indication by the United States food and drug
- 41    administration.
- 42     3. Alter any law with regard to provisions that limit the coverage
- 43    of prescription drugs that have not been approved by the United States
- 44    food and drug administration.

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

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

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

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

12       1. The acceptable standard medical reference compendia are the  
13 following:

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

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

18       (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

33       (c) The literature meets the uniform requirements for manuscripts  
34 submitted to biomedical journals established by the international  
35 committee of medical journal editors or is published in a journal  
36 specified by the United States department of health and human services as  
37 acceptable peer reviewed medical literature pursuant to section  
38 186(t)(2)(B) of the social security act (42 United States Code section  
39 1395x(t)(2)(B)).

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

1       R. The metabolic disorders triggering medical foods coverage under  
2 this section shall:

3       1. Be part of the newborn screening program prescribed in section  
4 36-694.

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

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

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

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

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

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

27       1. Prescription drugs shall also provide coverage for any  
28 prescribed drug or device that is approved by the United States food and  
29 drug administration for use as a contraceptive. A blanket disability  
30 insurer may use a drug formulary, multitiered drug formulary or list but  
31 that formulary or list shall include oral, implant and injectable  
32 contraceptive drugs, intrauterine devices and prescription barrier  
33 methods. The blanket disability insurer may not impose deductibles,  
34 coinsurance, copayments or other cost containment measures for  
35 contraceptive drugs, ~~that are greater than the deductibles, coinsurance,~~  
~~copayments or other cost containment measures for other drugs on the same~~  
~~level of the formulary or list~~ INTRAUTERINE DEVICES, PRESCRIPTION BARRIER  
METHODS, OVER-THE-COUNTER CONTRACEPTION, CONTRACEPTIVE IMPLANTS,  
THERAPEUTIC EQUIVALENTS OR STERILIZATION.

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

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

24        ~~W. Subsection V of this section does not authorize a religiously~~  
25 ~~affiliated employer to obtain an employee's protected health information~~  
26 ~~or to violate the health insurance portability and accountability act of~~  
27 ~~1996 (P.L. 104-191, 110 Stat. 1936) or any federal regulations adopted~~  
28 ~~pursuant to that act.~~

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

32        ~~Y. V. For the purposes of:~~

33        1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~amended.~~ (b) An entity whose articles of incorporation clearly state that it

~~is a religiously motivated organization and whose religious beliefs are central to the organization's operating principles.~~