

REFERENCE TITLE: insurance coverage; autologous breast reconstruction

State of Arizona
Senate
Fifty-seventh Legislature
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2026

SB 1604

Introduced by
Senators Alston: Angius, Bravo, Diaz, Epstein, Gabaldón, Gonzales,
Miranda, Ortiz, Sears, Sundareshan; Representative Connolly

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1383, 20-1402, 20-1404 AND
20-2341, 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
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. 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:

30 1. THAT IS incidental to the patient's covered mastectomy for
31 surgical services for reconstruction of the breast on which the mastectomy
32 was performed, surgery and reconstruction of the other breast to produce a
33 symmetrical appearance, prostheses, treatment of physical complications
34 for all stages of the mastectomy, including lymphedemas, and at least two
35 external postoperative prostheses subject to all of the terms and
36 conditions of the policy.

37 2. FOR AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURES AND ANY RELATED
38 MEDICALLY NECESSARY SERVICE, PROCEDURE AND IMAGING, INCLUDING REVISIONS TO
39 AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE. ALL OF THE FOLLOWING APPLY
40 TO COVERAGE FOR AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE:

41 (a) THE COVERAGE MAY NOT:

42 (i) BE LESS FAVORABLE THAN THE COVERAGE FOR OTHER COVERED BREAST
43 RECONSTRUCTION SERVICES.

44 (ii) BE SUBJECT TO ANY TERMS AND CONDITIONS, INCLUDING
45 OUT-OF-POCKET EXPENSES SUCH AS COPAYMENTS, DEDUCTIBLES AND COINSURANCE,

1 UNLESS THE TERMS AND CONDITIONS ALSO APPLY UNDER THE CONTRACT FOR
2 IN-NETWORK PROVIDERS.

3 (b) THE COVERAGE SHALL:

4 (i) SATISFY NETWORK ADEQUACY STANDARDS AS REQUIRED BY FEDERAL AND
5 STATE LAW.

6 (ii) COMPLY WITH THE ACCEPTED STANDARDS OF CARE AND CLINICAL
7 PRACTICE GUIDELINES THAT ARE GENERALLY RECOGNIZED BY PROVIDERS AND
8 EVIDENCE-BASED SOURCES.

9 (iii) CONTRACT WITH A NETWORK OF PROVIDERS THAT IS SUFFICIENT IN
10 QUANTITY AND GEOGRAPHIC LOCATIONS TO ENSURE THAT THE SERVICES AND
11 PROCEDURES ARE ACCESSIBLE TO ALL SUBSCRIBERS WITHOUT UNREASONABLE DELAY.

12 (iv) ENSURE THAT ALL SUBSCRIBERS HAVE GEOGRAPHIC ACCESS WITHOUT
13 UNREASONABLE DELAY TO AN OUT-OF-NETWORK PROVIDER FOR THE SERVICES AND
14 PROCEDURES.

15 (v) BE SUBJECT TO UTILIZATION REVIEW REQUIREMENTS.

16 (c) AN OUT-OF-NETWORK PROVIDER MAY NOT CHARGE A SUBSCRIBER FOR THE
17 COST OF A COVERED SERVICE AND PROCEDURE IN AN AMOUNT IN EXCESS OF THE
18 REIMBURSEMENT PAID UNDER THE CONTRACT.

19 (d) A CONTRACT THAT REIMBURSES OUT-OF-NETWORK PROVIDERS FOR THE
20 SERVICES AND PROCEDURES SHALL REIMBURSE THE OUT-OF-NETWORK PROVIDERS AT
21 RATES THAT ARE NOT LESS THAN THE AVERAGE IN-NETWORK REIMBURSEMENT RATES
22 FOR COMPARABLE SERVICES AND PROCEDURES.

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

28 1. A mammogram.

29 2. Digital breast tomosynthesis, magnetic resonance imaging,
30 ultrasound or other modality and at such age and intervals as recommended
31 by the national comprehensive cancer network. This includes patients at
32 risk for breast cancer who have a family history with one or more first or
33 second degree relatives with breast cancer, prior diagnosis of breast
34 cancer, positive testing for hereditary gene mutations or heterogeneously
35 or dense breast tissue based on the breast imaging reporting and data
36 system of the American college of radiology.

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

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

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

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

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

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

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

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

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

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

- 42 1. Deny the mother or the newborn child eligibility or continued
43 eligibility to enroll or to renew coverage under the terms of the contract
44 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 O 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 O. Subsection N of this section does not:

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

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

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

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

30 1. Blood glucose monitors.

31 2. Blood glucose monitors for the legally blind.

32 3. Test strips for glucose monitors and visual reading and urine
33 testing strips.

34 4. Insulin preparations and glucagon.

35 5. Insulin cartridges.

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

37 7. Injection aids.

38 8. Insulin cartridges for the legally blind.

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

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

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

44 12. Any other device, medication, equipment or supply for which
45 coverage is required under medicare from and after January 1, 1999. The

1 coverage required in this paragraph is effective six months after the
2 coverage is required under medicare.

3 Q. Subsection P of this section does not prohibit a medical service
4 corporation, a hospital service corporation or a hospital, medical, dental
5 and optometric service corporation from imposing deductibles, coinsurance
6 or other cost sharing in relation to benefits for equipment or supplies
7 for the treatment of diabetes.

8 R. Any hospital or medical service contract that provides coverage
9 for 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 S of this section or medical literature that
17 meets the criteria prescribed in subsection S 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 20-841.05, 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 5. Notwithstanding section 20-841.05, prohibit a contract from
35 limiting or excluding coverage of a prescription drug, if the decision to
36 limit or exclude coverage of the prescription drug is not based primarily
37 on the coverage of prescription drugs required by this section.

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

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

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

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

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

3 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

25 T. A corporation shall not issue or deliver any advertising matter
26 or sales material to any person in this state until the corporation files
27 the advertising matter or sales material with the director. This
28 subsection does not require a corporation to have the prior approval of
29 the director to issue or deliver the advertising matter or sales material.
30 If the director finds that the advertising matter or sales material, in
31 whole or in part, is false, deceptive or misleading, the director may
32 issue an order disapproving the advertising matter or sales material,
33 directing the corporation to cease and desist from issuing, circulating,
34 displaying or using the advertising matter or sales material within a
35 period of time specified by the director but not less than ten days and
36 imposing any penalties prescribed in this title. At least five days
37 before issuing an order pursuant to this subsection, the director shall
38 provide the corporation with a written notice of the basis of the order to
39 provide the corporation with an opportunity to cure the alleged deficiency
40 in the advertising matter or sales material within a single five-day
41 period for the particular advertising matter or sales material at issue.
42 The corporation may appeal the director's order pursuant to title 41,
43 chapter 6, article 10. Except as otherwise provided in this subsection, a
44 corporation may obtain a stay of the effectiveness of the order as
45 prescribed in section 20-162. If the director certifies in the order and

1 provides a detailed explanation of the reasons in support of the
2 certification that continued use of the advertising matter or sales
3 material poses a threat to the health, safety or welfare of the public,
4 the order may be entered immediately without opportunity for cure and the
5 effectiveness of the order is not stayed pending the hearing on the notice
6 of appeal but the hearing shall be promptly instituted and determined.

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

11 V. The metabolic disorders triggering medical foods coverage under
12 this section shall:

13 1. Be part of the newborn screening program prescribed in section
14 36-694.

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

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

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

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

29 X. A hospital service corporation or medical service corporation
30 shall cover at least fifty percent of the cost of medical foods prescribed
31 to treat inherited metabolic disorders and covered pursuant to this
32 section. A hospital service corporation or medical service corporation
33 may limit the maximum annual benefit for medical foods under this section
34 to \$5,000, which applies to the cost of all prescribed modified low
35 protein foods and metabolic formula.

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

38 1. If the contract provides coverage for prescription drugs, the
39 contract shall provide coverage for any prescribed drug or device that is
40 approved by the United States food and drug administration for use as a
41 contraceptive. A corporation may use a drug formulary, multitiered drug
42 formulary or list but that formulary or list shall include oral, implant
43 and injectable contraceptive drugs, intrauterine devices and prescription
44 barrier methods. The corporation may not impose deductibles,
45 coinsurance, copayments or other cost containment measures for

1 contraceptive drugs that are greater than the deductibles, coinsurance,
2 copayments or other cost containment measures for other drugs on the same
3 level of the formulary or list.

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

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

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

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

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

1 CC. For the purposes of:

2 1. This section:

3 (a) "Inherited metabolic disorder":

4 (i) Means a disease THAT IS caused by an inherited abnormality of
5 body chemistry. ~~and~~

6 (ii) Includes a disease THAT IS tested under the newborn screening
7 program prescribed in section 36-694.

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

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

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

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

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

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

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 E 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 3. SUBSECTION H OF THIS SECTION:

41 (a) "AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE" INCLUDES ALL OF
42 THE FOLLOWING:

43 (i) SUPERIOR GLUTEAL ARTERY PERFORATOR FLAP.

44 (ii) INFERIOR GLUTEAL ARTERY PERFORATION FLAP.

45 (iii) INTERCOSTAL ARTERY PERFORATOR FLAP.

- 1 (iv) LATERAL THIGH PERFORATOR FLAP.
- 2 (v) LUMBAR ARTERY PERFORATOR FLAP.
- 3 (vi) MUSCLE SPARKING TRANSVERSE UPPER GRACILIS FLAP.
- 4 (vii) PROFUNDA ARTERY PERFORATOR FLAP.
- 5 (viii) SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP.
- 6 (ix) ABDOMINAL PERFORATOR EXCHANGE FLAP.
- 7 (x) THORACODORSAL ARTERY PERFORATOR FLAP.
- 8 (xi) BODY LIFT PERFORATOR FLAP.
- 9 (xii) STACKED HEMIABDOMINAL EXTENDED PERFORATOR FLAP.
- 10 (xiii) DEEP INFERIOR EPIGASTRIC PERFORATOR ARTERY.
- 11 (xiv) HYBRID PROCEDURES THAT INVOLVE BOTH AN AUTOLOGOUS BREAST
- 12 RECONSTRUCTION PROCEDURE AND BREAST IMPLANTATIONS.

13 (b) "REVISIONS TO AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE"
14 INCLUDES ANY OF THE FOLLOWING:

- 15 (i) LIPOSUCTION.
- 16 (ii) GRAFTING.
- 17 (iii) NIPPLE RECONSTRUCTION.
- 18 (iv) NIPPLE AND AREOLA TATTOOS.
- 19 (v) FAT NECROSIS EXCISION.
- 20 (vi) CAPSULOTOMY.
- 21 (vii) BREAST CAPSULORRHAPHY.

22 ~~3.~~ 4. Subsections Z and AA of this section, "religiously
23 affiliated employer" means either:

- 24 (a) An entity for which all of the following apply:
 - 25 (i) The entity primarily employs persons who share the religious
 - 26 tenets of the entity.
 - 27 (ii) The entity primarily serves persons who share the religious
 - 28 tenets of the entity.
 - 29 (iii) The entity is a nonprofit organization as described in
 - 30 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as
 - 31 amended.

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

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

37 20-1057. Evidence of coverage by health care services
38 organizations; renewability; definitions

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

41 B. Any contract, except accidental death and dismemberment, applied
42 for that provides family coverage shall also provide, as to such coverage
43 of family members, that the benefits applicable for children shall be
44 payable with respect to a newly born child of the enrollee from the
45 instant of such child's birth, to a child adopted by the enrollee,

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

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

21 D. An evidence of coverage or amendment to the coverage shall not
22 be issued or delivered to any person in this state until a copy of the
23 form of the evidence of coverage or amendment to the coverage has been
24 filed with and approved by the director.

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

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

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

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

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

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

40 G. The director shall approve any form of evidence of coverage if
41 the requirements of subsections E and F of this section are met. It is
42 unlawful to issue such form until approved. If the director does not
43 disapprove any such form within forty-five days after the filing of the
44 form, it is deemed approved. If the director disapproves a form of
45 evidence of coverage, the director shall notify the health care services

1 organization. In the notice, the director shall specify the reasons for
2 the director's disapproval. The director shall grant a hearing on such
3 disapproval within fifteen days after a request for a hearing in writing
4 is received from the health care services organization.

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

33 I. A health care plan that provides coverage for surgical services
34 for a mastectomy shall also provide coverage:

35 1. THAT IS incidental to the patient's covered mastectomy for
36 surgical services for reconstruction of the breast on which the mastectomy
37 was performed, surgery and reconstruction of the other breast to produce a
38 symmetrical appearance, prostheses, treatment of physical complications
39 for all stages of the mastectomy, including lymphedemas, and at least two
40 external postoperative prostheses subject to all of the terms and
41 conditions of the policy.

42 2. FOR AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURES AND ANY RELATED
43 MEDICALLY NECESSARY SERVICE, PROCEDURE AND IMAGING, INCLUDING REVISIONS TO
44 AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE. ALL OF THE FOLLOWING APPLY
45 TO COVERAGE FOR AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE:

1 (a) THE COVERAGE MAY NOT:
2 (i) BE LESS FAVORABLE THAN THE COVERAGE FOR OTHER COVERED BREAST
3 RECONSTRUCTION SERVICES.
4 (ii) BE SUBJECT TO ANY TERMS AND CONDITIONS, INCLUDING
5 OUT-OF-POCKET EXPENSES SUCH AS COPAYMENTS, DEDUCTIBLES AND COINSURANCE,
6 UNLESS THE TERMS AND CONDITIONS ALSO APPLY UNDER THE HEALTH BENEFIT PLAN
7 FOR IN-NETWORK PROVIDERS.
8 (b) THE COVERAGE SHALL:
9 (i) SATISFY NETWORK ADEQUACY STANDARDS AS REQUIRED BY FEDERAL AND
10 STATE LAW.
11 (ii) COMPLY WITH THE ACCEPTED STANDARDS OF CARE AND CLINICAL
12 PRACTICE GUIDELINES THAT ARE GENERALLY RECOGNIZED BY PROVIDERS AND
13 EVIDENCE-BASED SOURCES.
14 (iii) CONTRACT WITH A NETWORK OF PROVIDERS THAT IS SUFFICIENT IN
15 QUANTITY AND GEOGRAPHIC LOCATIONS TO ENSURE THAT THE SERVICES AND
16 PROCEDURES ARE ACCESSIBLE TO ALL ENROLLEES WITHOUT UNREASONABLE DELAY.
17 (iv) ENSURE THAT ALL ENROLLEES HAVE GEOGRAPHIC ACCESS WITHOUT
18 UNREASONABLE DELAY TO AN OUT-OF-NETWORK PROVIDER FOR THE SERVICES AND
19 PROCEDURES.
20 (v) BE SUBJECT TO UTILIZATION REVIEW REQUIREMENTS.
21 (c) AN OUT-OF-NETWORK PROVIDER MAY NOT CHARGE AN ENROLLEE FOR THE
22 COST OF A COVERED SERVICE AND PROCEDURE IN AN AMOUNT IN EXCESS OF THE
23 REIMBURSEMENT PAID UNDER THE HEALTH BENEFIT'S PLAN.
24 (d) A HEALTH BENEFIT'S PLAN THAT REIMBURSES OUT-OF-NETWORK
25 PROVIDERS FOR THE SERVICES AND PROCEDURES SHALL REIMBURSE THE
26 OUT-OF-NETWORK PROVIDERS AT RATES THAT ARE NOT LESS THAN THE AVERAGE
27 IN-NETWORK REIMBURSEMENT RATES FOR COMPARABLE SERVICES AND PROCEDURES.
28 J. A contract that provides coverage for surgical services for a
29 mastectomy shall also provide coverage for preventive mammography
30 screening and diagnostic imaging performed on dedicated equipment for
31 diagnostic purposes on referral by a patient's physician, subject to all
32 of the terms and conditions of the policy, including:
33 1. A mammogram.
34 2. Digital breast tomosynthesis, magnetic resonance imaging,
35 ultrasound or other modality and at such age and intervals as recommended
36 by the national comprehensive cancer network. This includes patients at
37 risk for breast cancer who have a family history with one or more first or
38 second degree relatives with breast cancer, prior diagnosis of breast
39 cancer, positive testing for hereditary gene mutations or heterogeneously
40 or dense breast tissue based on the breast imaging reporting and data
41 system of the American college of radiology.
42 K. Any contract that is issued to the enrollee and that provides
43 coverage for maternity benefits shall also provide that the maternity
44 benefits apply to the costs of the birth of any child legally adopted by
45 the enrollee if all the following are true:

- 1 1. The child is adopted within one year of birth.
- 2 2. The enrollee is legally obligated to pay the costs of birth.
- 3 3. All preexisting conditions and other limitations have been met
- 4 and all deductibles and copayments have been paid by the enrollee.
- 5 4. The enrollee has notified the insurer of the enrollee's
- 6 acceptability to adopt children pursuant to section 8-105 within sixty
- 7 days after such approval or within sixty days after a change in insurance
- 8 policies, plans or companies.
- 9 L. The coverage prescribed by subsection K of this section is
- 10 excess to any other coverage the natural mother may have for maternity
- 11 benefits except coverage made available to persons pursuant to title 36,
- 12 chapter 29. If such other coverage exists the agency, attorney or
- 13 individual arranging the adoption shall make arrangements for the
- 14 insurance to pay those costs that may be covered under that policy and
- 15 shall advise the adopting parent in writing of the existence and extent of
- 16 the coverage without disclosing any confidential information such as the
- 17 identity of the natural parent. The enrollee adopting parents shall
- 18 notify their health care services organization of the existence and extent
- 19 of the other coverage. A health care services organization is not
- 20 required to pay any costs in excess of the amounts it would have been
- 21 obligated to pay to its hospitals and providers if the natural mother and
- 22 child had received the maternity and newborn care directly from or through
- 23 that health care services organization.
- 24 M. Each health care services organization shall offer membership to
- 25 the following in a conversion plan that provides the basic health care
- 26 benefits required by the director:
- 27 1. Each enrollee including the enrollee's enrolled dependents
- 28 leaving a group.
- 29 2. Each enrollee and the enrollee's dependents who would otherwise
- 30 cease to be eligible for membership because of the age of the enrollee or
- 31 the enrollee's dependents or the death or the dissolution of marriage of
- 32 an enrollee.
- 33 N. A health care services organization shall not cancel or nonrenew
- 34 an evidence of coverage issued to an individual on a nongroup basis,
- 35 including a conversion plan, except for any of the following reasons and
- 36 in compliance with the notice and disclosure requirements contained in
- 37 subsection H of this section:
- 38 1. The individual has failed to pay premiums or contributions in
- 39 accordance with the terms of the evidence of coverage or the health care
- 40 services organization has not received premium payments in a timely
- 41 manner.
- 42 2. The individual has performed an act or practice that constitutes
- 43 fraud or the individual made an intentional misrepresentation of material
- 44 fact under the terms of the evidence of coverage.

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

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

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

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

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

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

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

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

- 37 1. Conditions of eligibility.
- 38 2. Coverage of dependents.
- 39 3. Preexisting conditions.
- 40 4. Termination of insurance.
- 41 5. Probationary periods.
- 42 6. Limitations.
- 43 7. Exceptions.
- 44 8. Reductions.
- 45 9. Elimination periods.

1 10. Requirements for replacement.

2 11. Any other conditions of evidences of coverage.

3 R. Any contract that provides maternity benefits shall not restrict
4 benefits for any hospital length of stay in connection with childbirth for
5 the mother or the newborn child to less than forty-eight hours following a
6 normal vaginal delivery or ninety-six hours following a cesarean section.
7 The contract shall not require the provider to obtain authorization from
8 the health care services organization for prescribing the minimum length
9 of stay required by this subsection. The contract may provide that an
10 attending provider in consultation with the mother may discharge the
11 mother or the newborn child before the expiration of the minimum length of
12 stay required by this subsection. The health care services organization
13 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 S 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 S. Subsection R 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 a health care services organization from imposing
34 deductibles, coinsurance or other cost sharing in relation to benefits for
35 hospital lengths of stay in connection with childbirth for a mother or a
36 newborn child under the contract, except that any coinsurance or other
37 cost sharing for any portion of a period within a hospital length of stay
38 required pursuant to subsection R of this section shall not be greater
39 than the coinsurance or cost sharing for any preceding portion of that
40 stay.

41 3. Prevent a health care services organization from negotiating the
42 level and type of reimbursement with a provider for care provided in
43 accordance with subsection R of this section.

44 T. Any contract or evidence of coverage that provides coverage for
45 diabetes shall also provide coverage for equipment and supplies that are

1 medically necessary and that are prescribed by a health care provider
2 including:

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

21 U. Subsection T of this section does not:

- 22 1. Entitle a member or enrollee of a health care services
23 organization to equipment or supplies for the treatment of diabetes that
24 are not medically necessary as determined by the health care services
25 organization medical director or the medical director's designee.
- 26 2. Provide coverage for diabetic supplies obtained by a member or
27 enrollee of a health care services organization without a prescription
28 unless otherwise allowed pursuant to the terms of the health care plan.
- 29 3. Prohibit a health care services organization from imposing
30 deductibles, coinsurance or other cost sharing in relation to benefits for
31 equipment or supplies for the treatment of diabetes.

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

15 5. Notwithstanding section 20-1057.02, prohibit a contract or
16 evidence of coverage from limiting or excluding coverage of a prescription
17 drug, if the decision to limit or exclude coverage of the prescription
18 drug is not based primarily on the coverage of prescription drugs required
19 by this section.

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

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

24 1. The acceptable standard medical reference compendia are the
25 following:

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

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

30 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

44 1. Be part of the newborn screening program prescribed in section
45 36-694.

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

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

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

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

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

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

25 DD. For the purposes of:

26 1. This section:

27 (a) "Inherited metabolic disorder":

28 (i) Means a disease THAT IS caused by an inherited abnormality of
29 body chemistry. ~~and~~

30 (ii) Includes a disease THAT IS tested under the newborn screening
31 program prescribed in section 36-694.

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

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

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

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

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

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

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

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

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

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

22 3. SUBSECTION I OF THIS SECTION:

23 (a) "AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE" INCLUDES ALL OF
24 THE FOLLOWING:

25 (i) SUPERIOR GLUTEAL ARTERY PERFORATOR FLAP.

26 (ii) INFERIOR GLUTEAL ARTERY PERFORATION FLAP.

27 (iii) INTERCOSTAL ARTERY PERFORATOR FLAP.

28 (iv) LATERAL THIGH PERFORATOR FLAP.

29 (v) LUMBAR ARTERY PERFORATOR FLAP.

30 (vi) MUSCLE SPARKING TRANSVERSE UPPER GRACILIS FLAP.

31 (vii) PROFUNDA ARTERY PERFORATOR FLAP.

32 (viii) SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP.

33 (ix) ABDOMINAL PERFORATOR EXCHANGE FLAP.

34 (x) THORACODORSAL ARTERY PERFORATOR FLAP.

35 (xi) BODY LIFT PERFORATOR FLAP.

36 (xii) STACKED HEMIABDOMINAL EXTENDED PERFORATOR FLAP.

37 (xiii) DEEP INFERIOR EPIGASTRIC PERFORATOR ARTERY.

38 (xiv) HYBRID PROCEDURES THAT INVOLVE BOTH AN AUTOLOGOUS BREAST
39 RECONSTRUCTION PROCEDURE AND BREAST IMPLANTATIONS.

40 (b) "REVISIONS TO AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE"
41 INCLUDES ANY OF THE FOLLOWING:

42 (i) LIPOSUCTION.

43 (ii) GRAFTING.

44 (iii) NIPPLE RECONSTRUCTION.

45 (iv) NIPPLE AND AREOLA TATTOOS.

1 (v) FAT NECROSIS EXCISION.

2 (vi) CAPSULOTOMY.

3 (vii) BREAST CAPSULORRHAPHY.

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

6 20-1342. Scope and format of policy; definitions

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

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

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

14 3. It shall purport to insure only one person, except that a policy
15 may insure, originally or by subsequent amendment, on the application of
16 the policyholder or the policyholder's spouse, any two or more eligible
17 members of that family, including husband, wife, dependent children or any
18 children under a specified age that does not exceed nineteen years and any
19 other person dependent on the policyholder. Any policy, except accidental
20 death and dismemberment, applied for that provides family coverage, as to
21 such 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 may require that notification of birth, adoption or adoption
34 placement of the child and payment of the required premium must be
35 furnished to the insurer within thirty-one days after the date of birth,
36 adoption or adoption placement in order to have the coverage continue
37 beyond the thirty-one day period.

38 4. The style, arrangement and overall appearance of the policy
39 shall give no undue prominence to any portion of the text, and every
40 printed portion of the text of the policy and of any endorsements or
41 attached papers shall be plainly printed in light-faced type of a style in
42 general use, the size of which shall be uniform and not less than ten
43 point with a lower case unspaced alphabet length of not less than one
44 hundred and twenty point. "Text" shall include all printed matter except

1 the name and address of the insurer, name or title of the policy, the
2 brief description, if any, and captions and subcaptions.

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

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

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

20 8. Each contract shall be so written that the corporation shall pay
21 benefits:

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

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

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

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

34 9. A disability insurance policy that provides coverage for the
35 surgical expense of a mastectomy shall also provide coverage:

36 (a) THAT IS incidental to the patient's covered mastectomy for the
37 expense of reconstructive surgery of the breast on which the mastectomy
38 was performed, surgery and reconstruction of the other breast to produce a
39 symmetrical appearance, prostheses, treatment of physical complications
40 for all stages of the mastectomy, including lymphedemas, and at least two
41 external postoperative prostheses subject to all of the terms and
42 conditions of the policy.

43 (b) FOR AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURES AND ANY RELATED
44 MEDICALLY NECESSARY SERVICE, PROCEDURE AND IMAGING, INCLUDING REVISIONS TO
45 AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE.

1 10. ALL OF THE FOLLOWING APPLY TO THE COVERAGE PRESCRIBED BY
2 PARAGRAPH 9, SUBDIVISION (b) OF THIS SUBSECTION:

3 (a) THE COVERAGE MAY NOT:

4 (i) BE LESS FAVORABLE THAN THE COVERAGE FOR OTHER COVERED BREAST
5 RECONSTRUCTION SERVICES.

6 (ii) BE SUBJECT TO ANY TERMS AND CONDITIONS, INCLUDING
7 OUT-OF-POCKET EXPENSES SUCH AS COPAYMENTS, DEDUCTIBLES AND COINSURANCE,
8 UNLESS THE TERMS AND CONDITIONS ALSO APPLY UNDER THE POLICY FOR IN-NETWORK
9 PROVIDERS.

10 (b) THE COVERAGE SHALL:

11 (i) SATISFY NETWORK ADEQUACY STANDARDS AS REQUIRED BY FEDERAL AND
12 STATE LAW.

13 (ii) COMPLY WITH THE ACCEPTED STANDARDS OF CARE AND CLINICAL
14 PRACTICE GUIDELINES THAT ARE GENERALLY RECOGNIZED BY PROVIDERS AND
15 EVIDENCE-BASED SOURCES.

16 (iii) CONTRACT WITH A NETWORK OF PROVIDERS THAT IS SUFFICIENT IN
17 QUANTITY AND GEOGRAPHIC LOCATIONS TO ENSURE THAT THE SERVICES AND
18 PROCEDURES ARE ACCESSIBLE TO ALL INSURED WITHOUT UNREASONABLE DELAY.

19 (iv) ENSURE THAT ALL INSURED HAVE GEOGRAPHIC ACCESS WITHOUT
20 UNREASONABLE DELAY TO AN OUT-OF-NETWORK PROVIDER FOR THE SERVICES AND
21 PROCEDURES.

22 (v) BE SUBJECT TO UTILIZATION REVIEW REQUIREMENTS.

23 (c) AN OUT-OF-NETWORK PROVIDER MAY NOT CHARGE AN INSURED FOR THE
24 COST OF A COVERED SERVICE AND PROCEDURE IN AN AMOUNT IN EXCESS OF THE
25 REIMBURSEMENT PAID UNDER THE POLICY.

26 (d) A POLICY THAT REIMBURSES OUT-OF-NETWORK PROVIDERS FOR THE
27 SERVICES AND PROCEDURES SHALL REIMBURSE THE OUT-OF-NETWORK PROVIDERS AT
28 RATES THAT ARE NOT LESS THAN THE AVERAGE IN-NETWORK REIMBURSEMENT RATES
29 FOR COMPARABLE SERVICES AND PROCEDURES.

30 ~~10.~~ 11. A contract, except a supplemental contract covering a
31 specified disease or other limited benefits, that provides coverage for
32 surgical services for a mastectomy shall also provide coverage for
33 preventive mammography screening and diagnostic imaging performed on
34 dedicated equipment for diagnostic purposes on referral by a patient's
35 physician, subject to all of the terms and conditions of the policy,
36 including:

37 (a) A mammogram.

38 (b) Digital breast tomosynthesis, magnetic resonance imaging,
39 ultrasound or other modality and at such age and intervals as recommended
40 by the national comprehensive cancer network. This includes patients at
41 risk for breast cancer who have a family history with one or more first or
42 second degree relatives with breast cancer, prior diagnosis of breast
43 cancer, positive testing for hereditary gene mutations or heterogeneously
44 or dense breast tissue based on the breast imaging reporting and data
45 system of the American college of radiology.

1 ~~11~~ 12. Any contract that is issued to the insured and that
2 provides coverage for maternity benefits shall also provide that the
3 maternity benefits apply to the costs of the birth of any child legally
4 adopted by the insured if all the following are true:

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

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

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

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

13 ~~12~~ 13. The coverage prescribed by paragraph ~~11~~ 12 of this
14 subsection is excess to any other coverage the natural mother may have for
15 maternity benefits except coverage made available to persons pursuant to
16 title 36, chapter 29. If such other coverage exists the agency, attorney
17 or individual arranging the adoption shall make arrangements for the
18 insurance to pay those costs that may be covered under that policy and
19 shall advise the adopting parent in writing of the existence and extent of
20 the coverage without disclosing any confidential information such as the
21 identity of the natural parent. The insured adopting parents shall notify
22 their insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

5 C. Subsection B of this section does not:

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

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

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

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

21 1. Blood glucose monitors.

22 2. Blood glucose monitors for the legally blind.

23 3. Test strips for glucose monitors and visual reading and urine
24 testing strips.

25 4. Insulin preparations and glucagon.

26 5. Insulin cartridges.

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

28 7. Injection aids.

29 8. Insulin cartridges for the legally blind.

30 9. Syringes and lancets including automatic lancing devices.

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

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

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

39 E. Subsection D of this section does not:

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

43 2. Require a policy to provide an insured with outpatient benefits
44 if the policy does not cover outpatient benefits.

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:

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

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

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

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

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

23 1. Be part of the newborn screening program prescribed in section
24 36-694.

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

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

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

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

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

1 L. For the purposes of:

2 1. This section:

3 (a) "Inherited metabolic disorder":

4 (i) Means a disease THAT IS caused by an inherited abnormality of
5 body chemistry. ~~and~~

6 (ii) Includes a disease THAT IS tested under the newborn screening
7 program prescribed in section 36-694.

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

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

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

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

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

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

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

25 (i) Formulated to be consumed or administered enterally under the
26 supervision of a physician who is licensed pursuant to title 32, chapter
27 13 or 17 or a registered nurse practitioner who is licensed pursuant to
28 title 32, chapter 15.

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

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

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

38 2. Subsection A of this section: ~~the term~~

39 (a) "AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE" INCLUDES ALL OF
40 THE FOLLOWING:

41 (i) SUPERIOR GLUTEAL ARTERY PERFORATOR FLAP.

42 (ii) INFERIOR GLUTEAL ARTERY PERFORATION FLAP.

43 (iii) INTERCOSTAL ARTERY PERFORATOR FLAP.

44 (iv) LATERAL THIGH PERFORATOR FLAP.

45 (v) LUMBAR ARTERY PERFORATOR FLAP.

- 1 (vi) MUSCLE SPARKING TRANSVERSE UPPER GRACILIS FLAP.
- 2 (vii) PROFUNDA ARTERY PERFORATOR FLAP.
- 3 (viii) SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP.
- 4 (ix) ABDOMINAL PERFORATOR EXCHANGE FLAP.
- 5 (x) THORACODORSAL ARTERY PERFORATOR FLAP.
- 6 (xi) BODY LIFT PERFORATOR FLAP.
- 7 (xii) STACKED HEMIABDOMINAL EXTENDED PERFORATOR FLAP.
- 8 (xiii) DEEP INFERIOR EPIGASTRIC PERFORATOR ARTERY.
- 9 (xiv) HYBRID PROCEDURES THAT INVOLVE BOTH AN AUTOLOGOUS BREAST
- 10 RECONSTRUCTION PROCEDURE AND BREAST IMPLANTATIONS.

11 (b) "Child", for purposes of initial coverage of an adopted child
12 or a child placed for adoption but not for purposes of termination of
13 coverage of such child, means a person who is under eighteen years of age.

14 (c) "REVISIONS TO AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE"
15 INCLUDES ANY OF THE FOLLOWING:

- 16 (i) LIPOSUCTION.
- 17 (ii) GRAFTING.
- 18 (iii) NIPPLE RECONSTRUCTION.
- 19 (iv) NIPPLE AND AREOLA TATTOOS.
- 20 (v) FAT NECROSIS EXCISION.
- 21 (vi) CAPSULOTOMY.
- 22 (vii) BREAST CAPSULORRHAPHY.

23 Sec. 4. Section 20-1383, Arizona Revised Statutes, is amended to
24 read:

25 20-1383. Individual health insurance policies; mandatory
26 coverage exemption; definitions

27 A. A disability insurer may issue a policy to an uninsured
28 individual that is not subject to the requirements of any of the
29 following:

- 30 1. Section 20-461, subsection A, paragraph 17 and subsection B.
- 31 2. Section 20-1342, subsection A, paragraphs ~~11 and~~ 12 AND 13.
- 32 3. Section 20-1342, subsections H, I, J and K.
- 33 4. Section 20-1376, subsections A and C.
- 34 5. Sections 20-1342.01, 20-1376.01, 20-1376.02, 20-1376.03 and
- 35 20-1376.04.

36 B. For the purposes of this section:

37 1. "Health insurance coverage":

38 (a) Means a health care plan or arrangement that pays for or
39 furnishes medical or health services and that is issued by a disability
40 insurer, group disability insurer, blanket disability insurer, health care
41 services organization, hospital service corporation, medical service
42 corporation or medical, hospital, dental and optometric service
43 corporation or a similar entity in another state.

44 (b) Includes a self-insured or self-funded employee benefit plan or
45 multiemployer employee benefit plan created pursuant to 29 United States

1 Code section 186(c) if the regulation of that plan is preempted by section
2 514(b) of the employee retirement ~~insurance~~ INCOME security act of 1974
3 (29 United States Code section 1144(b)).

4 (c) Does not include limited benefit coverage as defined in section
5 20-1137.

6 2. "Uninsured individual" means a person who has either:

7 (a) Not had health insurance coverage for the ninety days
8 immediately before the effective date of coverage issued pursuant to this
9 section, except that this requirement does not apply at the renewal of
10 coverage pursuant to this section.

11 (b) Lost health insurance coverage in one of the following ways
12 within ninety days immediately before the effective date of coverage
13 issued pursuant to this section:

14 (i) The individual left a job that provided health insurance
15 coverage.

16 (ii) The individual's employer discontinued offering health
17 insurance coverage.

18 (iii) The individual exhausted continuation coverage under a COBRA
19 continuation provision as defined in section 20-2301.

20 (iv) The individual's family health insurance coverage was
21 discontinued due to the death of a spouse or a divorce.

22 (v) The individual attained the maximum age for dependent coverage
23 under a health insurance policy.

24 (vi) The individual's participation in a public health care program
25 was discontinued.

26 Sec. 5. Section 20-1402, Arizona Revised Statutes, is amended to
27 read:

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

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

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

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

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

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

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

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

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

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

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

35 5. A group disability insurance policy that provides coverage for
36 the surgical expense of a mastectomy shall also provide coverage:

37 (a) THAT IS incidental to the patient's covered mastectomy for the
38 expense of reconstructive surgery of the breast on which the mastectomy
39 was performed, surgery and reconstruction of the other breast to produce a
40 symmetrical appearance, prostheses, treatment of physical complications
41 for all stages of the mastectomy, including lymphedemas, and at least two
42 external postoperative prostheses subject to all of the terms and
43 conditions of the policy.

1 (b) FOR AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURES AND ANY RELATED
2 MEDICALLY NECESSARY SERVICE, PROCEDURE AND IMAGING, INCLUDING REVISIONS TO
3 AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE.

4 6. ALL OF THE FOLLOWING APPLY TO THE COVERAGE PRESCRIBED BY
5 PARAGRAPH 5, SUBDIVISION (b) OF THIS SUBSECTION:

6 (a) THE COVERAGE MAY NOT:

7 (i) BE LESS FAVORABLE THAN THE COVERAGE FOR OTHER COVERED BREAST
8 RECONSTRUCTION SERVICES.

9 (ii) BE SUBJECT TO ANY TERMS AND CONDITIONS, INCLUDING
10 OUT-OF-POCKET EXPENSES SUCH AS COPAYMENTS, DEDUCTIBLES AND COINSURANCE,
11 UNLESS THE TERMS AND CONDITIONS ALSO APPLY UNDER THE POLICY FOR IN-NETWORK
12 PROVIDERS.

13 (b) THIS COVERAGE SHALL:

14 (i) SATISFY NETWORK ADEQUACY STANDARDS AS REQUIRED BY FEDERAL AND
15 STATE LAW.

16 (ii) COMPLY WITH THE ACCEPTED STANDARDS OF CARE AND CLINICAL
17 PRACTICE GUIDELINES THAT ARE GENERALLY RECOGNIZED BY PROVIDERS AND
18 EVIDENCE-BASED SOURCES.

19 (iii) CONTRACT WITH A NETWORK OF PROVIDERS THAT IS SUFFICIENT IN
20 QUANTITY AND GEOGRAPHIC LOCATIONS TO ENSURE THAT THE SERVICES AND
21 PROCEDURES ARE ACCESSIBLE TO ALL INSURED WITHOUT UNREASONABLE DELAY.

22 (iv) ENSURE THAT ALL INSURED HAVE GEOGRAPHIC ACCESS WITHOUT
23 UNREASONABLE DELAY TO AN OUT-OF-NETWORK PROVIDER FOR THE SERVICES AND
24 PROCEDURES.

25 (v) BE SUBJECT TO UTILIZATION REVIEW REQUIREMENTS.

26 (c) AN OUT-OF-NETWORK PROVIDER MAY NOT CHARGE AN INSURED FOR THE
27 COST OF A COVERED SERVICE AND PROCEDURE IN AN AMOUNT IN EXCESS OF THE
28 REIMBURSEMENT PAID UNDER THE POLICY.

29 (d) A POLICY THAT REIMBURSES OUT-OF-NETWORK PROVIDERS FOR THE
30 SERVICES AND PROCEDURES SHALL REIMBURSE THE OUT-OF-NETWORK PROVIDERS AT
31 RATES THAT ARE NOT LESS THAN THE AVERAGE IN-NETWORK REIMBURSEMENT RATES
32 FOR COMPARABLE SERVICES AND PROCEDURES.

33 ~~6.~~ 7. A contract, except a supplemental contract covering a
34 specified disease or other limited benefits, that provides coverage for
35 surgical services for a mastectomy shall also provide coverage for
36 preventive mammography screening and diagnostic imaging performed on
37 dedicated equipment for diagnostic purposes on referral by a patient's
38 physician, subject to all of the terms and conditions of the policy,
39 including:

40 (a) A mammogram.

41 (b) Digital breast tomosynthesis, magnetic resonance imaging,
42 ultrasound or other modality and at such age and intervals as recommended
43 by the national comprehensive cancer network. This includes patients at
44 risk for breast cancer who have a family history with one or more first or
45 second degree relatives with breast cancer, prior diagnosis of breast

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

4 ~~7.~~ 8. Any contract that is issued to the insured and that provides
5 coverage for maternity benefits shall also provide that the maternity
6 benefits apply to the costs of the birth of any child legally adopted by
7 the insured if all the following are true:

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

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

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

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

16 ~~8.~~ 9. The coverage prescribed by paragraph ~~7~~ 8 of this subsection
17 is excess to any other coverage the natural mother may have for maternity
18 benefits except coverage made available to persons pursuant to title 36,
19 chapter 29. If such other coverage exists the agency, attorney or
20 individual arranging the adoption shall make arrangements for the
21 insurance to pay those costs that may be covered under that policy and
22 shall advise the adopting parent in writing of the existence and extent of
23 the coverage without disclosing any confidential information such as the
24 identity of the natural parent. The insured adopting parents shall notify
25 their insurer of the existence and extent of the other coverage.

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

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

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

42 3. Penalize or otherwise reduce or limit the reimbursement of an
43 attending provider because that provider provided care to any insured
44 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.

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

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

3 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. The group disability insurer 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":

12 (i) Means a disease THAT IS caused by an inherited abnormality of
13 body chemistry. ~~and~~

14 (ii) Includes a disease THAT IS tested under the newborn screening
15 program prescribed in section 36-694.

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

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

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

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

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

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

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

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

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

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

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

- 1 2. Subsection A of this section: ~~, the term~~
2 (a) "AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE" INCLUDES ALL OF
3 THE FOLLOWING:
4 (i) SUPERIOR GLUTEAL ARTERY PERFORATOR FLAP.
5 (ii) INFERIOR GLUTEAL ARTERY PERFORATION FLAP.
6 (iii) INTERCOSTAL ARTERY PERFORATOR FLAP.
7 (iv) LATERAL THIGH PERFORATOR FLAP.
8 (v) LUMBAR ARTERY PERFORATOR FLAP.
9 (vi) MUSCLE SPARKING TRANSVERSE UPPER GRACILIS FLAP.
10 (vii) PROFUNDA ARTERY PERFORATOR FLAP.
11 (viii) SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP.
12 (ix) ABDOMINAL PERFORATOR EXCHANGE FLAP.
13 (x) THORACODORSAL ARTERY PERFORATOR FLAP.
14 (xi) BODY LIFT PERFORATOR FLAP.
15 (xii) STACKED HEMIABDOMINAL EXTENDED PERFORATOR FLAP.
16 (xiii) DEEP INFERIOR EPIGASTRIC PERFORATOR ARTERY.
17 (xiv) HYBRID PROCEDURES THAT INVOLVE BOTH AN AUTOLOGOUS BREAST
18 RECONSTRUCTION PROCEDURE AND BREAST IMPLANTATIONS.
19 (b) "Child", for purposes of initial coverage of an adopted child
20 or a child placed for adoption but not for purposes of termination of
21 coverage of such child, means a person who is under eighteen years of age.
22 (c) "REVISIONS TO AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE"
23 INCLUDES ANY OF THE FOLLOWING:
24 (i) LIPOSUCTION.
25 (ii) GRAFTING.
26 (iii) NIPPLE RECONSTRUCTION.
27 (iv) NIPPLE AND AREOLA TATTOOS.
28 (v) FAT NECROSIS EXCISION.
29 (vi) CAPSULOTOMY.
30 (vii) BREAST CAPSULORRHAPHY.
31 3. Subsections M and N of this section, "religiously affiliated
32 employer" means either:
33 (a) An entity for which all of the following apply:
34 (i) The entity primarily employs persons who share the religious
35 tenets of the entity.
36 (ii) The entity serves primarily persons who share the religious
37 tenets of the entity.
38 (iii) The entity is a nonprofit organization as described in
39 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as
40 amended.
41 (b) An entity whose articles of incorporation clearly state that it
42 is a religiously motivated organization and whose religious beliefs are
43 central to the organization's operating principles.

1 Sec. 6. Section 20-1404, Arizona Revised Statutes, is amended to
2 read:

3 20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 G. A blanket disability insurance policy that provides coverage for
35 the surgical expense of a mastectomy shall also provide coverage:

36 1. THAT IS incidental to the patient's covered mastectomy for the
37 expense of reconstructive surgery of the breast on which the mastectomy
38 was performed, surgery and reconstruction of the other breast to produce a
39 symmetrical appearance, prostheses, treatment of physical complications
40 for all stages of the mastectomy, including lymphedemas, and at least two
41 external postoperative prostheses subject to all of the terms and
42 conditions of the policy.

43 2. FOR AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURES AND ANY RELATED
44 MEDICALLY NECESSARY SERVICE, PROCEDURE AND IMAGING, INCLUDING REVISIONS TO

1 AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE. ALL OF THE FOLLOWING APPLY
2 TO COVERAGE FOR AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE:

3 (a) THE COVERAGE MAY NOT:

4 (i) BE LESS FAVORABLE THAN THE COVERAGE FOR OTHER COVERED BREAST
5 RECONSTRUCTION SERVICES.

6 (ii) BE SUBJECT TO ANY TERMS AND CONDITIONS, INCLUDING
7 OUT-OF-POCKET EXPENSES SUCH AS COPAYMENTS, DEDUCTIBLES AND COINSURANCE
8 UNLESS THE TERMS AND CONDITIONS ALSO APPLY UNDER THE POLICY FOR IN-NETWORK
9 PROVIDERS.

10 (b) THE COVERAGE SHALL:

11 (i) SATISFY NETWORK ADEQUACY STANDARDS AS REQUIRED BY FEDERAL AND
12 STATE LAW.

13 (ii) COMPLY WITH THE ACCEPTED STANDARDS OF CARE AND CLINICAL
14 PRACTICE GUIDELINES THAT ARE GENERALLY RECOGNIZED BY PROVIDERS AND
15 EVIDENCE-BASED SOURCES.

16 (iii) CONTRACT WITH A NETWORK OF PROVIDERS THAT IS SUFFICIENT IN
17 QUANTITY AND GEOGRAPHIC LOCATIONS TO ENSURE THAT THE SERVICES AND
18 PROCEDURES ARE ACCESSIBLE TO ALL INSURED WITHOUT UNREASONABLE DELAY.

19 (iv) ENSURE THAT ALL INSURED HAVE GEOGRAPHIC ACCESS WITHOUT
20 UNREASONABLE DELAY TO AN OUT-OF-NETWORK PROVIDER FOR THE SERVICES AND
21 PROCEDURES.

22 (v) BE SUBJECT TO UTILIZATION REVIEW REQUIREMENTS.

23 (c) AN OUT-OF-NETWORK PROVIDER MAY NOT CHARGE AN INSURED FOR THE
24 COST OF A COVERED SERVICE AND PROCEDURE IN AN AMOUNT IN EXCESS OF THE
25 REIMBURSEMENT PAID UNDER THE POLICY.

26 (d) A POLICY THAT REIMBURSES OUT-OF-NETWORK PROVIDERS FOR THE
27 SERVICES AND PROCEDURES SHALL REIMBURSE THE OUT-OF-NETWORK PROVIDERS AT
28 RATES THAT ARE NOT LESS THAN THE AVERAGE IN-NETWORK REIMBURSEMENT RATES
29 FOR COMPARABLE SERVICES AND PROCEDURES.

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

35 1. A mammogram.

36 2. Digital breast tomosynthesis, magnetic resonance imaging,
37 ultrasound or other modality and at such age and intervals as recommended
38 by the national comprehensive cancer network. This includes patients at
39 risk for breast cancer who have a family history with one or more first or
40 second degree relatives with breast cancer, prior diagnosis of breast
41 cancer, positive testing for hereditary gene mutations or heterogeneously
42 or dense breast tissue based on the breast imaging reporting and data
43 system of the American college of radiology.

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

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

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

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

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

21 K. 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 insurer for prescribing the minimum length of stay required by this
27 subsection. The contract may provide that an attending provider in
28 consultation with the mother may discharge the mother or the newborn child
29 before the expiration of the minimum length of stay required by this
30 subsection. The insurer shall not:

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

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

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

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

43 5. Except as described in subsection L of this section, restrict
44 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 L. Subsection K of this section does not:

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

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

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

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

19 1. Blood glucose monitors.

20 2. Blood glucose monitors for the legally blind.

21 3. Test strips for glucose monitors and visual reading and urine
22 testing strips.

23 4. Insulin preparations and glucagon.

24 5. Insulin cartridges.

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

26 7. Injection aids.

27 8. Insulin cartridges for the legally blind.

28 9. Syringes and lancets including automatic lancing devices.

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

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

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

37 N. Subsection M of this section does not prohibit a blanket
38 disability insurer from imposing deductibles, coinsurance or other cost
39 sharing in relation to benefits for equipment or supplies for the
40 treatment of diabetes.

41 O. Any contract that provides coverage for prescription drugs shall
42 not limit or exclude coverage for any prescription drug prescribed for the
43 treatment of cancer on the basis that the prescription drug has not been
44 approved by the United States food and drug administration for the
45 treatment of the specific type of cancer for which the prescription drug

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

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

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

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

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

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

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

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

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

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

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

35 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Y. For the purposes of:

2 1. This section:

3 (a) "Inherited metabolic disorder":

4 (i) Means a disease caused by an inherited abnormality of body
5 chemistry. ~~and~~

6 (ii) Includes a disease tested under the newborn screening program
7 prescribed in section 36-694.

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

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

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

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

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

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

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

25 (i) Formulated to be consumed or administered enterally under the
26 supervision of a physician who is licensed pursuant to title 32, chapter
27 13 or 17 or a registered nurse practitioner who is licensed pursuant to
28 title 32, chapter 15.

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

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

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

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

42 3. SUBSECTION G OF THIS SECTION:

43 (a) "AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE" INCLUDES ALL OF
44 THE FOLLOWING:

45 (i) SUPERIOR GLUTEAL ARTERY PERFORATOR FLAP.

- 1 (ii) INFERIOR GLUTEAL ARTERY PERFORATION FLAP.
- 2 (iii) INTERCOSTAL ARTERY PERFORATOR FLAP.
- 3 (iv) LATERAL THIGH PERFORATOR FLAP.
- 4 (v) LUMBAR ARTERY PERFORATOR FLAP.
- 5 (vi) MUSCLE SPARKING TRANSVERSE UPPER GRACILIS FLAP.
- 6 (vii) PROFUNDA ARTERY PERFORATOR FLAP.
- 7 (viii) SUPERFICIAL INFERIOR EPIGASTRIC ARTERY FLAP.
- 8 (ix) ABDOMINAL PERFORATOR EXCHANGE FLAP.
- 9 (x) THORACODORSAL ARTERY PERFORATOR FLAP.
- 10 (xi) BODY LIFT PERFORATOR FLAP.
- 11 (xii) STACKED HEMIABDOMINAL EXTENDED PERFORATOR FLAP.
- 12 (xiii) DEEP INFERIOR EPIGASTRIC PERFORATOR ARTERY.
- 13 (xiv) HYBRID PROCEDURES THAT INVOLVE BOTH AN AUTOLOGOUS BREAST
- 14 RECONSTRUCTION PROCEDURE AND BREAST IMPLANTATIONS.

15 (b) "REVISIONS TO AN AUTOLOGOUS BREAST RECONSTRUCTION PROCEDURE"
16 INCLUDES ANY OF THE FOLLOWING:

- 17 (i) LIPOSUCTION.
- 18 (ii) GRAFTING.
- 19 (iii) NIPPLE RECONSTRUCTION.
- 20 (iv) NIPPLE AND AREOLA TATTOOS.
- 21 (v) FAT NECROSIS EXCISION.
- 22 (vi) CAPSULOTOMY.
- 23 (vii) BREAST CAPSULORRHAPHY.

24 ~~3.~~ 4. Subsections V and W of this section, "religiously affiliated
25 employer" means either:

- 26 (a) An entity for which all of the following apply:
 - 27 (i) The entity primarily employs persons who share the religious
 - 28 tenets of the entity.
 - 29 (ii) The entity serves primarily persons who share the religious
 - 30 tenets of the entity.
 - 31 (iii) The entity is a nonprofit organization as described in
 - 32 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as
 - 33 amended.
- 34 (b) An entity whose articles of incorporation clearly state that it
- 35 is a religiously motivated organization and whose religious beliefs are
- 36 central to the organization's operating principles.

37 Sec. 7. Section 20-2341, Arizona Revised Statutes, is amended to
38 read:

39 20-2341. Uninsured small business health insurance plans;
40 mandatory coverage exemption; definitions

41 A. A policy, subscription contract, contract, plan or evidence of
42 coverage issued to an uninsured small business by a health care insurer is
43 not subject to the requirements of any of the following:

- 44 1. Section 20-461, subsection A, paragraph 17 and subsection B.
- 45 2. Section 20-826, subsection C, paragraph 1.

- 1 3. Section 20-826, subsections F, J, K, U, V, W, X and Y.
- 2 4. Sections 20-841, 20-841.01, 20-841.02, 20-841.03, 20-841.04,
- 3 20-841.06, 20-841.07 and 20-841.08.
- 4 5. Section 20-841.05, subsections B and E.
- 5 6. Section 20-1057, subsections C, K, L, Y, Z, AA and BB.
- 6 7. Sections 20-1057.01, 20-1057.03, 20-1057.04, 20-1057.05 and
- 7 20-1057.08.
- 8 8. Section 20-1057.02, subsection B.
- 9 9. Section 20-1342, subsection A, paragraph 8, subdivision (a).
- 10 10. Section 20-1342, subsection A, paragraphs ~~11 and~~ 12 AND 13.
- 11 11. Section 20-1342, subsections H, I, J and K.
- 12 12. Section 20-1342.01.
- 13 13. Sections 20-1376, 20-1376.01, 20-1376.02, 20-1376.03 and
- 14 20-1376.04.
- 15 14. Section 20-1402, subsection A, paragraph 4, subdivision (a).
- 16 15. Section 20-1402, subsection A, paragraphs ~~7 and~~ 8 AND 9.
- 17 16. Section 20-1402, subsections H, I, J, K and L.
- 18 17. Section 20-1404, subsection F, paragraph 1.
- 19 18. Section 20-1404, subsections I, Q, R, S, T and U.
- 20 19. Section 20-1406.
- 21 20. Sections 20-1406.01, 20-1406.02, 20-1406.03 and 20-1406.04.
- 22 21. Section 20-1407.
- 23 22. Section 20-2321.
- 24 23. Section 20-2327.
- 25 24. Section 20-2329.
- 26 B. Section 20-2304, subsection B does not apply to a policy,
- 27 subscription contract, contract, plan or evidence of coverage issued to an
- 28 uninsured small business pursuant to subsection A of this section.
- 29 C. In this article, unless the context otherwise requires:
- 30 1. "Health care insurer" means a disability insurer, group
- 31 disability insurer, blanket disability insurer, health care services
- 32 organization, hospital service corporation, medical service corporation or
- 33 hospital and medical service corporation.
- 34 2. "Uninsured small business" means a small employer that did not
- 35 provide a health benefits plan for at least ninety days immediately before
- 36 the effective date of coverage provided pursuant to this section, except
- 37 that this requirement does not apply at the renewal of coverage pursuant
- 38 to this section.