START\_STATUTE20-1402.  Provisions of group disability policies; definitions

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

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

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

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

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

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

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

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

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

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

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

(a)  A mammogram.

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

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

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

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

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

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

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

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

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

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

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

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

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

C.  Subsection B of this section does not:

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

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

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

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

1.  Blood glucose monitors.

2.  Blood glucose monitors for the legally blind.

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

4.  Insulin preparations and glucagon.

5.  Insulin cartridges.

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

7.  Injection aids.

8.  Insulin cartridges for the legally blind.

9.  Syringes and lancets including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c)  Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

2.  Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

L.  Any group disability policy that provides coverage for:

1.  Prescription drugs shall also provide coverage for any prescribed drug or device that is approved by the United States food and drug administration for use as a contraceptive.  A group disability insurer may use a drug formulary, multitiered drug formulary or list but that formulary or list shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods.  The group disability insurer may not impose deductibles, coinsurance, copayments or other cost containment measures for contraceptive drugs that are greater than the deductibles, coinsurance, copayments or other cost containment measures for other drugs on the same level of the formulary or list.

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

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

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

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

P.  For the purposes of:

1.  This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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