

REFERENCE TITLE: breast examinations; cancer screenings; definition

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

SB 1648

Introduced by
Senators Burch: Alston, Farnsworth, Fernandez, Gabaldón, Gonzales, Marsh,
Mendez, Miranda; Representatives Terech, Travers

AN ACT

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

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 ~~3.~~ 2. A mammogram every year for a woman ~~fifty~~ WHO IS FORTY years
5 of age and over.

6 3. A MAMMOGRAM AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
7 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

8 4. A MAMMOGRAM OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS
9 IF:

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

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

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

17 5. A MAGNETIC RESONANCE IMAGING OR ULTRASOUND OF THE ENTIRE BREAST
18 OR BOTH BREASTS IF THE PATIENT:

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

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

27 6. A MAMMOGRAM, ULTRASOUND OR MAGNETIC RESONANCE IMAGING IF THE
28 PATIENT HAS A HISTORY OF BREAST CANCER.

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

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

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

35 3. All preexisting conditions and other limitations have been met
36 by the insured.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 1. Blood glucose monitors.

27 2. Blood glucose monitors for the legally blind.

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

30 4. Insulin preparations and glucagon.

31 5. Insulin cartridges.

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

33 7. Injection aids.

34 8. Insulin cartridges for the legally blind.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 CC. For the purposes of:

2 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 ~~3.~~ 2. A mammogram every year for a woman ~~fifty~~ WHO IS FORTY years
25 of age and over.

26 3. A MAMMOGRAM AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
27 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

28 4. A MAMMOGRAM OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS
29 IF:

30 (a) A SCREENING MAMMOGRAM REVEALS ANY ABNORMALITY WHERE AN
31 ADDITIONAL EXAMINATION IS DEEMED MEDICALLY NECESSARY BY THE RADIOLOGIST
32 INTERPRETING THE MAMMOGRAM.

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

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

37 5. A MAGNETIC RESONANCE IMAGING OR ULTRASOUND OF THE ENTIRE BREAST
38 OR BOTH BREASTS IF THE PATIENT:

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

42 (b) HAS ADDITIONAL RISK FACTORS FOR BREAST CANCER, INCLUDING FAMILY
43 HISTORY OR PRIOR HISTORY OF BREAST CANCER, POSITIVE GENETIC TESTING,
44 HETEROGENEOUSLY OR EXTREMELY DENSE BREAST TISSUE BASED ON THE BREAST

1 IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF RADIOLOGY OR
2 OTHER RISK FACTORS AS DETERMINED BY THE PATIENT'S HEALTH CARE PROVIDER.

3 6. A MAMMOGRAM, ULTRASOUND OR MAGNETIC RESONANCE IMAGING IF THE
4 PATIENT HAS A HISTORY OF BREAST CANCER.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 44 1. Conditions of eligibility.
- 45 2. Coverage of dependents.

- 1 3. Preexisting conditions.
- 2 4. Termination of insurance.
- 3 5. Probationary periods.
- 4 6. Limitations.
- 5 7. Exceptions.
- 6 8. Reductions.
- 7 9. Elimination periods.
- 8 10. Requirements for replacement.
- 9 11. Any other conditions of evidences of coverage.
- 10 R. Any contract that provides maternity benefits shall not restrict
- 11 benefits for any hospital length of stay in connection with childbirth for
- 12 the mother or the newborn child to less than forty-eight hours following a
- 13 normal vaginal delivery or ninety-six hours following a cesarean section.
- 14 The contract shall not require the provider to obtain authorization from
- 15 the health care services organization for prescribing the minimum length
- 16 of stay required by this subsection. The contract may provide that an
- 17 attending provider in consultation with the mother may discharge the
- 18 mother or the newborn child before the expiration of the minimum length of
- 19 stay required by this subsection. The health care services organization
- 20 shall not:
 - 21 1. Deny the mother or the newborn child eligibility or continued
 - 22 eligibility to enroll or to renew coverage under the terms of the contract
 - 23 solely for the purpose of avoiding the requirements of this subsection.
 - 24 2. Provide monetary payments or rebates to mothers to encourage
 - 25 those mothers to accept less than the minimum protections available
 - 26 pursuant to this subsection.
 - 27 3. Penalize or otherwise reduce or limit the reimbursement of an
 - 28 attending provider because that provider provided care to any insured
 - 29 under the contract in accordance with this subsection.
 - 30 4. Provide monetary or other incentives to an attending provider to
 - 31 induce that provider to provide care to an insured under the contract in a
 - 32 manner that is inconsistent with this subsection.
 - 33 5. Except as described in subsection S of this section, restrict
 - 34 benefits for any portion of a period within the minimum length of stay in
 - 35 a manner that is less favorable than the benefits provided for any
 - 36 preceding portion of that stay.
- 37 S. ~~Nothing in~~ Subsection R of this section **DOES NOT**:
- 38 1. ~~Requires~~ **REQUIRE** a mother to give birth in a hospital or to stay
- 39 in the hospital for a fixed period of time following the birth of the
- 40 child.
- 41 2. ~~Prevents~~ **PREVENT** a health care services organization from
- 42 imposing deductibles, coinsurance or other cost sharing in relation to
- 43 benefits for hospital lengths of stay in connection with childbirth for a
- 44 mother or a newborn child under the contract, except that any coinsurance
- 45 or other cost sharing for any portion of a period within a hospital length

1 of stay required pursuant to subsection R of this section shall not be
2 greater than the coinsurance or cost sharing for any preceding portion of
3 that stay.

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

7 T. Any contract or evidence of coverage that provides coverage for
8 diabetes shall also provide coverage for equipment and supplies that are
9 medically necessary and that are prescribed by a health care provider
10 including:

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

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

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

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

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

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

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

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

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

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

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

23 5. Notwithstanding section 20-1057.02, prohibit a contract or
24 evidence of coverage from limiting or excluding coverage of a prescription
25 drug, if the decision to limit or exclude coverage of the prescription
26 drug is not based primarily on the coverage of prescription drugs required
27 by this section.

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

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

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

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

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

38 (c) Thomson Micromedex compendium DrugDex.

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

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

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

44 (a) At least two articles from major peer reviewed professional
45 medical journals have recognized, based on scientific or medical criteria,

1 the drug's safety and effectiveness for treatment of the indication for
2 which the drug has been prescribed.

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

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

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

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

5 Z. The metabolic disorders triggering medical foods coverage under
6 this section shall:

7 1. Be part of the newborn screening program prescribed in section
8 36-694.

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

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

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

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

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

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

33 DD. For the purposes of:

34 1. This section:

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

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

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

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

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

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

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

9 (d) "Modified low protein foods" means foods that are all of the
10 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 contain less than one gram of
16 protein per unit of serving, but does not include a natural food that is
17 naturally low in protein.

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

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

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

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

30 20-1342. Scope and format of policy; definitions

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

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

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

38 3. It shall purport to insure only one person, except that a policy
39 may insure, originally or by subsequent amendment, on the application of
40 the policyholder or the policyholder's spouse, any two or more eligible
41 members of that family, including husband, wife, dependent children or any
42 children under a specified age that does not exceed nineteen years and any
43 other person dependent ~~upon~~ ON the policyholder. Any policy, except
44 accidental death and dismemberment, applied for that provides family
45 coverage ~~shall~~, as to such coverage of family members, shall also provide

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

17 4. The style, arrangement and overall appearance of the policy
18 shall give no undue prominence to any portion of the text, and every
19 printed portion of the text of the policy and of any endorsements or
20 attached papers shall be plainly printed in light-faced type of a style in
21 general use, the size of which shall be uniform and not less than ten
22 point with a lower case unspaced alphabet length of not less than one
23 hundred and twenty point. "Text" shall include all printed matter except
24 the name and address of the insurer, name or title of the policy, the
25 brief description, if any, and captions and subcaptions.

26 5. The exceptions and reductions of indemnity shall be set forth in
27 the policy and, other than those contained in sections 20-1345 through
28 20-1368, shall be printed and, at the insurer's option, either included
29 with the benefit provision to which they apply or under an appropriate
30 caption such as "exceptions", or "exceptions and reductions", except that
31 if an exception or reduction specifically applies only to a particular
32 benefit of the policy, a statement of such exception or reduction shall be
33 included with the benefit provision to which it applies.

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

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

1 8. Each contract shall be so written that the corporation shall pay
2 benefits:

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

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

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

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

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

23 10. A contract, except a supplemental contract covering a specified
24 disease or other limited benefits, that provides coverage for surgical
25 services for a mastectomy shall also provide coverage for mammography
26 screening performed on dedicated equipment for diagnostic purposes on
27 referral by a patient's physician, subject to all of the terms and
28 conditions of the policy and according to the following guidelines:

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

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

34 (c) (b) A mammogram every year for a woman ~~fifty~~ WHO IS FORTY
35 years of age and over.

36 (c) A MAMMOGRAM AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
37 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

38 (d) A MAMMOGRAM OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS
39 IF:

40 (i) A SCREENING MAMMOGRAM REVEALS ANY ABNORMALITY WHERE AN
41 ADDITIONAL EXAMINATION IS DEEMED MEDICALLY NECESSARY BY THE RADIOLOGIST
42 INTERPRETING THE MAMMOGRAM.

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

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

3 (e) A MAGNETIC RESONANCE IMAGING OR ULTRASOUND OF THE ENTIRE BREAST
4 OR BOTH BREASTS IF THE PATIENT:

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

8 (ii) HAS ADDITIONAL RISK FACTORS FOR BREAST CANCER, INCLUDING
9 FAMILY HISTORY OR PRIOR HISTORY OF BREAST CANCER, POSITIVE GENETIC
10 TESTING, HETEROGENEOUSLY OR EXTREMELY DENSE BREAST TISSUE BASED ON THE
11 BREAST IMAGING REPORTING AND DATA SYSTEM OF THE AMERICAN COLLEGE OF
12 RADIOLOGY OR OTHER RISK FACTORS AS DETERMINED BY THE PATIENT'S HEALTH CARE
13 PROVIDER.

14 (f) A MAMMOGRAM, ULTRASOUND OR MAGNETIC RESONANCE IMAGING, IF THE
15 PATIENT HAS A HISTORY OF BREAST CANCER.

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

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

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

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

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

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

40 B. Any contract that provides maternity benefits shall not restrict
41 benefits for any hospital length of stay in connection with childbirth for
42 the mother or the newborn child to less than forty-eight hours following a
43 normal vaginal delivery or ninety-six hours following a cesarean section.
44 The contract shall not require the provider to obtain authorization from
45 the insurer for prescribing the minimum length of stay required by this

1 subsection. The contract may provide that an attending provider in
2 consultation with the mother may discharge the mother or the newborn child
3 before the expiration of the minimum length of stay required by this
4 subsection. The insurer shall not:

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

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

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

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

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

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

22 1. ~~Requires~~ **REQUIRE** a mother to give birth in a hospital or to stay
23 in the hospital for a fixed period of time following the birth of the
24 child.

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

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

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

39 1. Blood glucose monitors.

40 2. Blood glucose monitors for the legally blind.

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

43 4. Insulin preparations and glucagon.

44 5. Insulin cartridges.

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

- 1 7. Injection aids.
- 2 8. Insulin cartridges for the legally blind.
- 3 9. Syringes and lancets including automatic lancing devices.
- 4 10. Prescribed oral agents for controlling blood sugar that are
- 5 included on the plan formulary.
- 6 11. To the extent coverage is required under medicare, podiatric
- 7 appliances for prevention of complications associated with diabetes.
- 8 12. Any other device, medication, equipment or supply for which
- 9 coverage is required under medicare from and after January 1, 1999. The
- 10 coverage required in this paragraph is effective six months after the
- 11 coverage is required under medicare.
- 12 E. ~~Nothing in~~ Subsection D of this section **DOES NOT:**
- 13 1. ~~Prohibits~~ **PROHIBIT** a disability insurer from imposing
- 14 deductibles, coinsurance or other cost sharing in relation to benefits for
- 15 equipment or supplies for the treatment of diabetes.
- 16 2. ~~Requires~~ **REQUIRE** a policy to provide an insured with outpatient
- 17 benefits if the policy does not cover outpatient benefits.
- 18 F. Any contract that provides coverage for prescription drugs shall
- 19 not limit or exclude coverage for any prescription drug prescribed for the
- 20 treatment of cancer on the basis that the prescription drug has not been
- 21 approved by the United States food and drug administration for the
- 22 treatment of the specific type of cancer for which the prescription drug
- 23 has been prescribed, if the prescription drug has been recognized as safe
- 24 and effective for treatment of that specific type of cancer in one or more
- 25 of the standard medical reference compendia prescribed in subsection G of
- 26 this section or medical literature that meets the criteria prescribed in
- 27 subsection G of this section. The coverage required under this subsection
- 28 includes covered medically necessary services associated with the
- 29 administration of the prescription drug. This subsection does not:
- 30 1. Require coverage of any prescription drug used in the treatment
- 31 of a type of cancer if the United States food and drug administration has
- 32 determined that the prescription drug is contraindicated for that type of
- 33 cancer.
- 34 2. Require coverage for any experimental prescription drug that is
- 35 not approved for any indication by the United States food and drug
- 36 administration.
- 37 3. Alter any law with regard to provisions that limit the coverage
- 38 of prescription drugs that have not been approved by the United States
- 39 food and drug administration.
- 40 4. Require reimbursement or coverage for any prescription drug that
- 41 is not included in the drug formulary or list of covered prescription
- 42 drugs specified in the contract.
- 43 5. Prohibit a contract from limiting or excluding coverage of a
- 44 prescription drug, if the decision to limit or exclude coverage of the

1 prescription drug is not based primarily on the coverage of prescription
2 drugs required by this section.

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

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

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

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

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

13 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

41 1. Be part of the newborn screening program prescribed in section
42 36-694.

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

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

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

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

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

21 L. For the purposes of:

22 1. This section:

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

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

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

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

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

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

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

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

43 (i) Formulated to be consumed or administered enterally under the
44 supervision of a physician who is licensed pursuant to title 32, chapter

1 13 or 17 or a registered nurse practitioner who is licensed pursuant to
2 title 32, chapter 15.

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

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

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

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

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

18 20-1402. Provisions of group disability policies; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 ~~(c)~~ (b) A mammogram every year for a woman ~~fifty~~ WHO IS FORTY
2 years of age and over.

3 (c) A MAMMOGRAM AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
4 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

5 (d) A MAMMOGRAM OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS
6 IF:

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

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

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

14 (e) A MAGNETIC RESONANCE IMAGING OR ULTRASOUND OF THE ENTIRE BREAST
15 OR BOTH BREASTS IF THE PATIENT:

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

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

25 (f) A MAMMOGRAM, ULTRASOUND OR MAGNETIC RESONANCE IMAGING IF THE
26 PATIENT HAS A HISTORY OF BREAST CANCER.

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

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

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

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

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

39 8. The coverage prescribed by paragraph 7 of this subsection is
40 excess to any other coverage the natural mother may have for maternity
41 benefits except coverage made available to persons pursuant to title 36,
42 chapter 29, ~~but not including coverage made available to persons defined~~
43 ~~as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)~~
44 ~~and (e)~~. If such other coverage exists the agency, attorney or individual
45 arranging the adoption shall make arrangements for the insurance to pay

1 those costs that may be covered under that policy and shall advise the
2 adopting parent in writing of the existence and extent of the coverage
3 without disclosing any confidential information such as the identity of
4 the natural parent. The insured adopting parents shall notify their
5 insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

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

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

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

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

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

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

22 E. ~~Nothing in~~ Subsection D of this section ~~prohibits~~ DOES NOT
23 PROHIBIT a group disability insurer from imposing deductibles, coinsurance
24 or other cost sharing in relation to benefits for equipment or supplies
25 for the treatment of diabetes.

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

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

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

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

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

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

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

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

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

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

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

21 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

36 (c) The literature meets the uniform requirements for manuscripts
37 submitted to biomedical journals established by the international
38 committee of medical journal editors or is published in a journal
39 specified by the United States department of health and human services as
40 acceptable peer reviewed medical literature pursuant to section
41 186(t)(2)(B) of the social security act (42 United States Code section
42 1395x(t)(2)(B)).

43 H. Any contract that is offered by a group disability insurer and
44 that contains a prescription drug benefit shall provide coverage of

1 medical foods to treat inherited metabolic disorders as provided by this
2 section.

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

5 1. Be part of the newborn screening program prescribed in section
6 36-694.

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

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

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

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

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

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

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

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

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

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

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

32 P. For the purposes of:

33 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41 20-1404. Blanket disability insurance: definitions

42 A. Blanket disability insurance is that form of disability
43 insurance covering special groups of persons as enumerated in one of the
44 following paragraphs:

- 1 1. Under a policy or contract issued to any common carrier or to
2 any operator, owner or lessee of a means of transportation, which shall be
3 deemed the policyholder, covering a group defined as all persons who may
4 become passengers on such common carrier or means of transportation.
- 5 2. Under a policy or contract issued to an employer, who shall be
6 deemed the policyholder, covering all employees or any group of employees
7 defined by reference to hazards incident to an activity or activities or
8 operations of the policyholder. Dependents of the employees and guests of
9 the employer or employees may also be included where exposed to the same
10 hazards.
- 11 3. Under a policy or contract issued to a college, school or other
12 institution of learning or to the head or principal thereof, who or which
13 shall be deemed the policyholder, covering students, teachers, employees
14 or volunteers.
- 15 4. Under a policy or contract issued in the name of any volunteer
16 fire department or any first aid, civil defense or other such volunteer
17 group, or agency having jurisdiction thereof, which shall be deemed the
18 policyholder, covering all or any group of the members, participants or
19 volunteers of the fire department or first aid, civil defense or other
20 group.
- 21 5. Under a policy or contract issued to a creditor, who shall be
22 deemed the policyholder, to insure debtors of the creditor.
- 23 6. Under a policy or contract issued to a sports team or to a camp
24 or sponsor thereof, which team or camp or sponsor thereof shall be deemed
25 the policyholder, covering members, campers, employees, officials,
26 supervisors or volunteers.
- 27 7. Under a policy or contract issued to an incorporated or
28 unincorporated religious, charitable, recreational, educational or civic
29 organization, or branch thereof, which organization shall be deemed the
30 policyholder, covering any group of members, participants or volunteers
31 defined by reference to hazards incident to an activity or activities or
32 operations sponsored or supervised by or on the premises of the
33 policyholder.
- 34 8. Under a policy or contract issued to a newspaper or other
35 publisher, which shall be deemed the policyholder, covering its carriers.
- 36 9. Under a policy or contract issued to a restaurant, hotel, motel,
37 resort, innkeeper or other group with a high degree of potential customer
38 liability, which shall be deemed the policyholder, covering patrons or
39 guests.
- 40 10. Under a policy or contract issued to a health care provider or
41 other arranger of health services, which shall be deemed the policyholder,
42 covering patients, donors or surrogates provided that the coverage is not
43 made a condition of receiving care.

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

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

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

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

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

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

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

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

43 E. Any policy or contract, except accidental death and
44 dismemberment, applied for that provides family coverage, as to such
45 coverage of family members, shall also provide that the benefits

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

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

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

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

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

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

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

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

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

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

6 ~~3.~~ 2. A mammogram every year for a woman ~~fifty~~ WHO IS FORTY years
7 of age and over.

8 3. A MAMMOGRAM AT SUCH AGE AND INTERVALS AS DEEMED MEDICALLY
9 NECESSARY BY THE WOMAN'S HEALTH CARE PROVIDER.

10 4. A MAMMOGRAM OR ULTRASOUND OF THE ENTIRE BREAST OR BOTH BREASTS
11 IF:

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

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

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

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

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

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

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

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

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

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

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

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

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

1 chapter 29. If such other coverage exists the agency, attorney or
2 individual arranging the adoption shall make arrangements for the
3 insurance to pay those costs that may be covered under that policy and
4 shall advise the adopting parent in writing of the existence and extent of
5 the coverage without disclosing any confidential information such as the
6 identity of the natural parent. The insured adopting parents shall notify
7 their insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

39 (c) The literature meets the uniform requirements for manuscripts
40 submitted to biomedical journals established by the international
41 committee of medical journal editors or is published in a journal
42 specified by the United States department of health and human services as
43 acceptable peer reviewed medical literature pursuant to section
44 186(t)(2)(B) of the social security act (42 United States Code section
45 1395x(t)(2)(B)).

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

5 R. The metabolic disorders triggering medical foods coverage under
6 this section shall:

7 1. Be part of the newborn screening program prescribed in section
8 36-694.

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

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

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

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

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

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

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

42 2. Outpatient health care services shall also provide coverage for
43 outpatient contraceptive services. For the purposes of this paragraph,
44 "outpatient contraceptive services" means consultations, examinations,
45 procedures and medical services provided on an outpatient basis and

1 related to the use of approved United States food and drug administration
2 prescription contraceptive methods to prevent unintended pregnancies.

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

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

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

34 Y. For the purposes of:

35 1. This section:

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

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

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

42 (i) Formulated to be consumed or administered enterally under the
43 supervision of a physician who is licensed pursuant to title 32, chapter
44 13 or 17 or a registered nurse practitioner who is licensed pursuant to
45 title 32, chapter 15.

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

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

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

9 (d) "Modified low protein foods" means foods that are all of the
10 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 contain less than one gram of
16 protein per unit of serving, but does not include a natural food that is
17 naturally low in protein.

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

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

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

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

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

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

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

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

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

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

43 30-651. Definitions

44 In this chapter, unless the context otherwise requires:

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

3 2. "BREAST TOMOSYNTHESIS" MEANS X-RAY IMAGING OF A STATIONARY
4 BREAST THAT PRODUCES CROSS-SECTIONAL, THREE-DIMENSIONAL IMAGES.

5 ~~2.~~ 3. "By-product material" means any radioactive material, except
6 special nuclear material, yielded in or made radioactive by exposure to
7 the radiation incident to the process of producing or ~~utilizing~~ USING
8 special nuclear material and the tailings or wastes produced by the
9 extraction or concentration of uranium ore thorium from any ore processed
10 primarily for its source material content.

11 ~~3.~~ 4. "Department" means the department of health services.

12 ~~4.~~ 5. "Diagnostic mammography" means an x-ray imaging of the
13 breast performed on persons who have symptoms or physical signs indicative
14 of breast disease.

15 ~~5.~~ 6. "Director" means the director of the department.

16 ~~6.~~ 7. "Electronic product" means:

17 (a) Any machine or device designed to produce a beam of ionizing
18 radiation as the result of the operation of an electronic circuit or
19 component.

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

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

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

29 (e) Microwave and shortwave diathermy.

30 (f) Mercury vapor, metal halide and high-pressure sodium lamps used
31 for commercial lighting and industrial manufacturing processes or sunlamps
32 used in commercial establishments for the intentional irradiation of
33 humans.

34 (g) Therapeutic ultrasound devices.

35 (h) Industrial ultrasonic welders and sealers.

36 ~~7.~~ 8. "Electronic product radiation" means:

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

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

42 ~~8.~~ 9. "Ionizing radiation" means gamma rays and x-rays, alpha and
43 beta particles, high speed electrons, neutrons, protons and other nuclear
44 particles or rays.

1 ~~9.~~ 10. "Operation" means adjustments or procedures by the user
2 required for the equipment to perform its intended functions.

3 ~~10.~~ 11. "Person" means any individual, corporation, partnership,
4 firm, association, trust, estate, public or private institution, group,
5 agency or political subdivision of this state, or any other state or
6 political subdivision or agency of such state, and any legal successor,
7 representative, agent, or agency of the foregoing, other than the United
8 States nuclear regulatory commission or any successor, and other than
9 federal government agencies and any other entities licensed by the United
10 States nuclear regulatory commission or any successor.

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

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

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

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

19 ~~12.~~ 13. "Radiation machine" means any manufactured devices or
20 products producing any of the following:

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

23 (b) Electromagnetic radiation from an electronic product.

24 (c) Laser devices classified as class IIIB or IV by the United
25 States food and drug administration.

26 (d) Diathermy machines.

27 ~~13.~~ 14. "Radioactive material" means any material or materials,
28 solid, liquid or gaseous, that emit radiation spontaneously.

29 ~~14.~~ 15. "Screening mammography":

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

31 (b) INCLUDES BREAST TOMOSYNTHESIS.

32 ~~15.~~ 16. "Service" means major adjustments or repairs, usually
33 requiring specialized training or tools, or both.

34 ~~16.~~ 17. "Source material" means:

35 (a) Uranium, thorium or any other material that the governor
36 declares by order to be source material after the United States nuclear
37 regulatory commission or any successor has determined the material to be
38 source material.

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

1 ~~17.~~ 18. "Sources of radiation" means radioactive materials,
2 radiation machines and electronic products.
3 ~~18.~~ 19. "Special nuclear material":
4 (a) Means:
5 ~~(a)~~ (i) Plutonium, uranium 233, uranium enriched in the isotope
6 233 or in the isotope 235 and any other material that the governor
7 declares by order to be special nuclear material after the United States
8 nuclear regulatory commission or any successor has determined the material
9 to be special nuclear material, ~~but does not include source material.~~
10 ~~(b)~~ (ii) Any material artificially enriched by any of the material
11 provided in ~~subdivision (a)~~ ITEM (i) of this ~~paragraph~~ SUBDIVISION. ~~but~~
12 (b) Does not include source material.