

Senate Engrossed

breast examinations; cancer screenings; age

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

**CHAPTER 122**  
**SENATE BILL 1601**

AN ACT

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

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 4. Termination of insurance.

2 5. Probationary periods.

3 6. Limitations.

4 7. Exceptions.

5 8. Reductions.

6 9. Elimination periods.

7 10. Requirements for replacement.

8 11. Any other condition of subscription contracts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28           (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

26 CC. For the purposes of:

27 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 DD. For the purposes of:

2 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 20-1342. Scope and format of policy; definitions

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

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

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

5           3. It shall purport to insure only one person, except that a policy  
6 may insure, originally or by subsequent amendment, on the application of  
7 the policyholder or the policyholder's spouse, any two or more eligible  
8 members of that family, including husband, wife, dependent children or any  
9 children under a specified age that does not exceed nineteen years and any  
10 other person dependent ~~upon~~ ON the policyholder. Any policy, except  
11 accidental death and dismemberment, applied for that provides family  
12 coverage ~~shall~~, as to such coverage of family members, shall also provide  
13 that the benefits applicable for children shall be payable with respect to  
14 a newly born child of the insured from the instant of such child's birth,  
15 to a child adopted by the insured, regardless of the age at which the  
16 child was adopted, and to a child who has been placed for adoption with  
17 the insured and for whom the application and approval procedures for  
18 adoption pursuant to section 8-105 or 8-108 have been completed to the  
19 same extent that such coverage applies to other members of the family.  
20 The coverage for newly born or adopted children or children placed for  
21 adoption shall include coverage of injury or sickness including necessary  
22 care and treatment of medically diagnosed congenital defects and birth  
23 abnormalities. If payment of a specific premium is required to provide  
24 coverage for a child, the policy may require that notification of birth,  
25 adoption or adoption placement of the child and payment of the required  
26 premium must be furnished to the insurer within thirty-one days after the  
27 date of birth, adoption or adoption placement in order to have the  
28 coverage continue beyond the thirty-one day period.

29           4. The style, arrangement and overall appearance of the policy  
30 shall give no undue prominence to any portion of the text, and every  
31 printed portion of the text of the policy and of any endorsements or  
32 attached papers shall be plainly printed in light-faced type of a style in  
33 general use, the size of which shall be uniform and not less than ten  
34 point with a lower case unspaced alphabet length of not less than one  
35 hundred and twenty point. "Text" shall include all printed matter except  
36 the name and address of the insurer, name or title of the policy, the  
37 brief description, if any, and captions and subcaptions.

38           5. The exceptions and reductions of indemnity shall be set forth in  
39 the policy and, other than those contained in sections 20-1345 through  
40 20-1368, shall be printed and, at the insurer's option, either included  
41 with the benefit provision to which they apply or under an appropriate  
42 caption such as "exceptions", or "exceptions and reductions", except that  
43 if an exception or reduction specifically applies only to a particular  
44 benefit of the policy, a statement of such exception or reduction shall be  
45 included with the benefit provision to which it applies.

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

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

10          8. Each contract shall be so written that the corporation shall pay  
11 benefits:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

32           1. Blood glucose monitors.

33           2. Blood glucose monitors for the legally blind.

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

36           4. Insulin preparations and glucagon.

37           5. Insulin cartridges.

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

39           7. Injection aids.

40           8. Insulin cartridges for the legally blind.

41           9. Syringes and lancets including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 L. For the purposes of:

13 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25           1. Blood glucose monitors.

26           2. Blood glucose monitors for the legally blind.

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

29           4. Insulin preparations and glucagon.

30           5. Insulin cartridges.

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

32           7. Injection aids.

33           8. Insulin cartridges for the legally blind.

34           9. Syringes and lancets including automatic lancing devices.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

42 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 N. Subsection M of this section does not authorize a religiously  
2 affiliated employer to obtain an employee's protected health information  
3 or to violate the health insurance portability and accountability act of  
4 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted  
5 pursuant to that act.

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

9 P. For the purposes of:

10 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20           20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28           (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38           Y. For the purposes of:

39           1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3           30-651. Definitions

4           In this chapter, unless the context otherwise requires:

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

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

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

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

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

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

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

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

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

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

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

34           (e) Microwave and shortwave diathermy.

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

39           (g) Therapeutic ultrasound devices.

40           (h) Industrial ultrasonic welders and sealers.

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

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

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

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

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

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

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

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

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

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

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

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

29 (b) Electromagnetic radiation from an electronic product.

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

32 (d) Diathermy machines.

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

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

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

37 (b) INCLUDES DIGITAL BREAST TOMOSYNTHESIS.

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

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

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



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

APPROVED BY THE GOVERNOR MAY 8, 2023.

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