

REFERENCE TITLE: supplemental breast exams; insurance; coverage

State of Arizona
Senate
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2024

SB 1099

Introduced by
Senators Miranda: Alston, Bennett, Bravo, Burch, Diaz, Epstein, Fernandez,
Gabaldón, Gonzales, Hernandez, Wadsack; Representatives Blattman,
Hernandez C, Terech

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1402, 20-1404 AND 36-2907,
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. A corporation may not cancel or refuse to renew any subscriber's
19 contract without giving notice of such cancellation or nonrenewal to the
20 subscriber under such contract. A notice by the corporation to the
21 subscriber of cancellation or nonrenewal of a subscription contract shall
22 be mailed to the named subscriber at least forty-five days before the
23 effective date of such cancellation or nonrenewal. The notice shall
24 include or be accompanied by a statement in writing of the reasons for
25 such action by the corporation. Failure of the corporation to comply with
26 this subsection shall invalidate any cancellation or nonrenewal except a
27 cancellation or nonrenewal for nonpayment of premium.

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

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

41 1. A mammogram.

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

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

5 **3. A SUPPLEMENTAL BREAST EXAMINATION.**

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

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

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

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

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

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

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

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

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

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

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

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

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

27 O. Subsection N of this section does not:

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

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

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

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

43 1. Blood glucose monitors.

44 2. Blood glucose monitors for the legally blind.

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

3 4. Insulin preparations and glucagon.

4 5. Insulin cartridges.

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

6 7. Injection aids.

7 8. Insulin cartridges for the legally blind.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

40 T. A corporation shall not issue or deliver any advertising matter
41 or sales material to any person in this state until the corporation files
42 the advertising matter or sales material with the director. This
43 subsection does not require a corporation to have the prior approval of
44 the director to issue or deliver the advertising matter or sales material.
45 If the director finds that the advertising matter or sales material, in

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

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

26 V. The metabolic disorders triggering medical foods coverage under
27 this section shall:

28 1. Be part of the newborn screening program prescribed in section
29 36-694.

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

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

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

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

1 X. A hospital service corporation or medical service corporation
2 shall cover at least fifty percent of the cost of medical foods prescribed
3 to treat inherited metabolic disorders and covered pursuant to this
4 section. A hospital service corporation or medical service corporation
5 may limit the maximum annual benefit for medical foods under this section
6 to \$5,000, which applies to the cost of all prescribed modified low
7 protein foods and metabolic formula.

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

10 1. If the contract provides coverage for prescription drugs, the
11 contract shall provide coverage for any prescribed drug or device that is
12 approved by the United States food and drug administration for use as a
13 contraceptive. A corporation may use a drug formulary, multitiered drug
14 formulary or list but that formulary or list shall include oral, implant
15 and injectable contraceptive drugs, intrauterine devices and prescription
16 barrier methods. The corporation may not impose deductibles, coinsurance,
17 copayments or other cost containment measures for contraceptive drugs that
18 are greater than the deductibles, coinsurance, copayments or other cost
19 containment measures for other drugs on the same level of the formulary or
20 list.

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

28 3. This subsection does not apply to contracts issued to
29 individuals on a nongroup basis.

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

1 abortifacient, abortion or sterilization purposes. A religiously
2 affiliated employer offering the plan may state religious beliefs in its
3 affidavit and may require the subscriber to first pay for the prescription
4 and then submit a claim to the hospital service corporation, medical
5 service corporation or hospital, medical, dental and optometric service
6 corporation along with evidence that the prescription is not for a purpose
7 covered by the objection. A hospital service corporation, medical service
8 corporation or hospital, medical, dental and optometric service
9 corporation may charge an administrative fee for handling these claims.

10 AA. Subsection Z of this section does not authorize a religiously
11 affiliated employer to obtain an employee's protected health information
12 or to violate the health insurance portability and accountability act of
13 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
14 pursuant to that act.

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

18 CC. For the purposes of:

19 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

7 (e) "SUPPLEMENTAL BREAST EXAMINATION" MEANS A MEDICALLY NECESSARY
8 AND APPROPRIATE EXAMINATION OF THE BREAST THAT USES BREAST MAGNETIC
9 RESONANCE IMAGING, BREAST ULTRASOUND OR BREAST PRESSURE ELASTOGRAPHY WHEN
10 COMBINED WITH A POINT OF CARE ULTRASOUND FOR EVALUATING IDENTIFIED
11 ABNORMALITIES AND THAT IS:

12 (i) USED TO SCREEN FOR BREAST CANCER WHEN AN ABNORMALITY IS NOT
13 SEEN OR SUSPECTED.

14 (ii) BASED ON PERSONAL OR FAMILY MEDICAL HISTORY, ADDITIONAL
15 FACTORS THAT MAY INCREASE A PATIENT'S RISK OF BREAST CANCER OR THE
16 PATIENT'S PERSONAL CHOICE FOR A REGULAR BREAST EXAMINATION, WITH THE
17 FREQUENCY OF THE EXAMINATION DETERMINED BY THE PATIENT AND THE PATIENT'S
18 PHYSICIAN.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 J. A contract that provides coverage for surgical services for a
43 mastectomy shall also provide coverage for preventive mammography
44 screening and diagnostic imaging performed on dedicated equipment for

1 diagnostic purposes on referral by a patient's physician, subject to all
2 of the terms and conditions of the policy, including:

3 1. A mammogram.

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

12 3. A SUPPLEMENTAL BREAST EXAMINATION.

13 K. Any contract that is issued to the enrollee 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 enrollee if all the following are true:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 1. Conditions of eligibility.

9 2. Coverage of dependents.

10 3. Preexisting conditions.

11 4. Termination of insurance.

12 5. Probationary periods.

13 6. Limitations.

14 7. Exceptions.

15 8. Reductions.

16 9. Elimination periods.

17 10. Requirements for replacement.

18 11. Any other conditions of evidences of coverage.

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

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

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

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

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

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

1 S. Subsection R of this section does not:

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

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

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

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

19 1. Blood glucose monitors.

20 2. Blood glucose monitors for the legally blind.

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

23 4. Insulin preparations and glucagon.

24 5. Insulin cartridges.

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

26 7. Injection aids.

27 8. Insulin cartridges for the legally blind.

28 9. Syringes and lancets including automatic lancing devices.

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

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

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

37 U. Subsection T of this section does not:

38 1. Entitle a member or enrollee of a health care services
39 organization to equipment or supplies for the treatment of diabetes that
40 are not medically necessary as determined by the health care services
41 organization medical director or the medical director's designee.

42 2. Provide coverage for diabetic supplies obtained by a member or
43 enrollee of a health care services organization without a prescription
44 unless otherwise allowed pursuant to the terms of the health care plan.

1 3. Prohibit a health care services organization from imposing
2 deductibles, coinsurance or other cost sharing in relation to benefits for
3 equipment or supplies for the treatment of diabetes.

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

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

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

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

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

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

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

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

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

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

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

1 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

12 Z. The metabolic disorders triggering medical foods coverage under
13 this section shall:

14 1. Be part of the newborn screening program prescribed in section
15 36-694.

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

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

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

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

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

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

40 DD. For the purposes of:

41 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

31 (e) "SUPPLEMENTAL BREAST EXAMINATION" MEANS A MEDICALLY NECESSARY
32 AND APPROPRIATE EXAMINATION OF THE BREAST THAT USES BREAST MAGNETIC
33 RESONANCE IMAGING, BREAST ULTRASOUND OR BREAST PRESSURE ELASTOGRAPHY WHEN
34 COMBINED WITH A POINT OF CARE ULTRASOUND FOR EVALUATING IDENTIFIED
35 ABNORMALITIES AND THAT IS:

36 (i) USED TO SCREEN FOR BREAST CANCER WHEN AN ABNORMALITY IS NOT
37 SEEN OR SUSPECTED.

38 (ii) BASED ON PERSONAL OR FAMILY MEDICAL HISTORY, ADDITIONAL
39 FACTORS THAT MAY INCREASE A PATIENT'S RISK OF BREAST CANCER OR THE
40 PATIENT'S PERSONAL CHOICE FOR A REGULAR BREAST EXAMINATION, WITH THE
41 FREQUENCY OF THE EXAMINATION DETERMINED BY THE PATIENT AND THE PATIENT'S
42 PHYSICIAN.

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

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

7 20-1342. Scope and format of policy; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 10. A contract, except a supplemental contract covering a specified
43 disease or other limited benefits, that provides coverage for surgical
44 services for a mastectomy shall also provide coverage for preventive
45 mammography screening and diagnostic imaging performed on dedicated

1 equipment for diagnostic purposes on referral by a patient's physician,
2 subject to all of the terms and conditions of the policy, including:

3 (a) A mammogram.

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

12 (c) **A SUPPLEMENTAL BREAST EXAMINATION.**

13 11. 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 the following are true:

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

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

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

21 (d) 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 12. The coverage prescribed by paragraph 11 of this subsection 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. If such other coverage exists the agency, attorney or
29 individual arranging the adoption shall make arrangements for the
30 insurance to pay those costs that may be covered under that policy and
31 shall advise the adopting parent in writing of the existence and extent of
32 the coverage without disclosing any confidential information such as the
33 identity of the natural parent. The insured adopting parents shall notify
34 their insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

17 C. Subsection B of this section does not:

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

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

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

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

33 1. Blood glucose monitors.

34 2. Blood glucose monitors for the legally blind.

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

37 4. Insulin preparations and glucagon.

38 5. Insulin cartridges.

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

40 7. Injection aids.

41 8. Insulin cartridges for the legally blind.

42 9. Syringes and lancets including automatic lancing devices.

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

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

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

7 E. Subsection D of this section does not:

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

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

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

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

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

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

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

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

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

- 1 G. For the purposes of subsection F of this section:
2 1. The acceptable standard medical reference compendia are the
3 following:
4 (a) The American hospital formulary service drug information, a
5 publication of the American society of health system pharmacists.
6 (b) The national comprehensive cancer network drugs and biologics
7 compendium.
8 (c) Thomson Micromedex compendium DrugDex.
9 (d) Elsevier gold standard's clinical pharmacology compendium.
10 (e) Other authoritative compendia as identified by the secretary of
11 the United States department of health and human services.
12 2. Medical literature may be accepted if all of the following
13 apply:
14 (a) At least two articles from major peer reviewed professional
15 medical journals have recognized, based on scientific or medical criteria,
16 the drug's safety and effectiveness for treatment of the indication for
17 which the drug has been prescribed.
18 (b) No article from a major peer reviewed professional medical
19 journal has concluded, based on scientific or medical criteria, that the
20 drug is unsafe or ineffective or that the drug's safety and effectiveness
21 cannot be determined for the treatment of the indication for which the
22 drug has been prescribed.
23 (c) The literature meets the uniform requirements for manuscripts
24 submitted to biomedical journals established by the international
25 committee of medical journal editors or is published in a journal
26 specified by the United States department of health and human services as
27 acceptable peer reviewed medical literature pursuant to section
28 186(t)(2)(B) of the social security act (42 United States Code section
29 1395x(t)(2)(B)).
30 H. Any contract that is offered by a disability insurer and that
31 contains a routine outpatient prescription drug benefit shall provide
32 coverage of medical foods to treat inherited metabolic disorders as
33 provided by this section.
34 I. The metabolic disorders triggering medical foods coverage under
35 this section shall:
36 1. Be part of the newborn screening program prescribed in section
37 36-694.
38 2. Involve amino acid, carbohydrate or fat metabolism.
39 3. Have medically standard methods of diagnosis, treatment and
40 monitoring including quantification of metabolites in blood, urine or
41 spinal fluid or enzyme or DNA confirmation in tissues.
42 4. Require specially processed or treated medical foods that are
43 generally available only under the supervision and direction of a
44 physician who is licensed pursuant to title 32, chapter 13 or 17 or a
45 registered nurse practitioner who is licensed pursuant to title 32,

1 chapter 15, that must be consumed throughout life and without which the
2 person may suffer serious mental or physical impairment.

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

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

14 L. For the purposes of:

15 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

7 (e) "SUPPLEMENTAL BREAST EXAMINATION" MEANS A MEDICALLY NECESSARY
8 AND APPROPRIATE EXAMINATION OF THE BREAST THAT USES BREAST MAGNETIC
9 RESONANCE IMAGING, BREAST ULTRASOUND OR BREAST PRESSURE ELASTOGRAPHY WHEN
10 COMBINED WITH A POINT OF CARE ULTRASOUND FOR EVALUATING IDENTIFIED
11 ABNORMALITIES AND THAT IS:

12 (i) USED TO SCREEN FOR BREAST CANCER WHEN AN ABNORMALITY IS NOT
13 SEEN OR SUSPECTED.

14 (ii) BASED ON PERSONAL OR FAMILY MEDICAL HISTORY, ADDITIONAL
15 FACTORS THAT MAY INCREASE A PATIENT'S RISK OF BREAST CANCER OR THE
16 PATIENT'S PERSONAL CHOICE FOR A REGULAR BREAST EXAMINATION, WITH THE
17 FREQUENCY OF THE EXAMINATION DETERMINED BY THE PATIENT AND THE PATIENT'S
18 PHYSICIAN.

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

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

25 20-1402. Provisions of group disability policies; definitions

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

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

35 2. A provision that the insurer will furnish to the policyholder,
36 for delivery to each employee or member of the insured group, an
37 individual certificate setting forth in summary form a statement of the
38 essential features of the insurance coverage of the employee or member and
39 to whom benefits are payable. If dependents or family members are
40 included in the coverage additional certificates need not be issued for
41 delivery to the dependents or family members. Any policy, except
42 accidental death and dismemberment, applied for that provides family
43 coverage, as to such coverage of family members, shall also provide that
44 the benefits applicable for children shall be payable with respect to a
45 newly born child of the insured from the instant of such child's birth, to

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

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

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

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

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

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

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

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

41 6. A contract, except a supplemental contract covering a specified
42 disease or other limited benefits, that provides coverage for surgical
43 services for a mastectomy shall also provide coverage for preventive
44 mammography screening and diagnostic imaging performed on dedicated

1 equipment for diagnostic purposes on referral by a patient's physician,
2 subject to all of the terms and conditions of the policy, including:

3 (a) A mammogram.

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

12 (c) A SUPPLEMENTAL BREAST EXAMINATION.

13 7. 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 the following are true:

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

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

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

21 (d) 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 8. The coverage prescribed by paragraph 7 of this subsection 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. If such other coverage exists the agency, attorney or
29 individual arranging the adoption shall make arrangements for the
30 insurance to pay those costs that may be covered under that policy and
31 shall advise the adopting parent in writing of the existence and extent of
32 the coverage without disclosing any confidential information such as the
33 identity of the natural parent. The insured adopting parents shall notify
34 their insurer of the existence and extent of the other coverage.

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

- 1 1. Deny the mother or the newborn child eligibility or continued
2 eligibility to enroll or to renew coverage under the terms of the policy
3 solely for the purpose of avoiding the requirements of this subsection.
- 4 2. Provide monetary payments or rebates to mothers to encourage
5 those mothers to accept less than the minimum protections available
6 pursuant to this subsection.
- 7 3. Penalize or otherwise reduce or limit the reimbursement of an
8 attending provider because that provider provided care to any insured
9 under the policy in accordance with this subsection.
- 10 4. Provide monetary or other incentives to an attending provider to
11 induce that provider to provide care to an insured under the policy in a
12 manner that is inconsistent with this subsection.
- 13 5. Except as described in subsection C of this section, restrict
14 benefits for any portion of a period within the minimum length of stay in
15 a manner that is less favorable than the benefits provided for any
16 preceding portion of that stay.
- 17 C. Subsection B of this section does not:
 - 18 1. Require a mother to give birth in a hospital or to stay in the
19 hospital for a fixed period of time following the birth of the child.
 - 20 2. Prevent an insurer from imposing deductibles, coinsurance or
21 other cost sharing in relation to benefits for hospital lengths of stay in
22 connection with childbirth for a mother or a newborn child under the
23 policy, except that any coinsurance or other cost sharing for any portion
24 of a period within a hospital length of stay required pursuant to
25 subsection B of this section shall not be greater than the coinsurance or
26 cost sharing for any preceding portion of that stay.
 - 27 3. Prevent an insurer from negotiating the level and type of
28 reimbursement with a provider for care provided in accordance with
29 subsection B of this section.
- 30 D. Any contract that provides coverage for diabetes shall also
31 provide coverage for equipment and supplies that are medically necessary
32 and that are prescribed by a health care provider including:
 - 33 1. Blood glucose monitors.
 - 34 2. Blood glucose monitors for the legally blind.
 - 35 3. Test strips for glucose monitors and visual reading and urine
36 testing strips.
 - 37 4. Insulin preparations and glucagon.
 - 38 5. Insulin cartridges.
 - 39 6. Drawing up devices and monitors for the visually impaired.
 - 40 7. Injection aids.
 - 41 8. Insulin cartridges for the legally blind.
 - 42 9. Syringes and lancets including automatic lancing devices.
 - 43 10. Prescribed oral agents for controlling blood sugar that are
44 included on the plan formulary.

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

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

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

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 group disability insurer and
28 that contains a prescription drug benefit shall provide coverage of
29 medical foods to treat inherited metabolic disorders as provided by this
30 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 percent of the cost of
7 medical foods prescribed to treat inherited metabolic disorders and
8 covered pursuant to this section. An insurer may limit the maximum annual
9 benefit for medical foods under this section to \$5,000, which applies to
10 the cost of all prescribed modified low protein foods and metabolic
11 formula.

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

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

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

30 M. Notwithstanding subsection L of this section, a religiously
31 affiliated employer may require that the insurer provide a group
32 disability policy without coverage for specific items or services required
33 under subsection L of this section because providing or paying for
34 coverage of the specific items or services is contrary to the religious
35 beliefs of the religiously affiliated employer offering the plan. If a
36 religiously affiliated employer objects to providing coverage for specific
37 items or services required under subsection L of this section, a written
38 affidavit shall be filed with the insurer stating the objection. On
39 receipt of the affidavit, the insurer shall issue to the religiously
40 affiliated employer a group disability policy that excludes coverage for
41 specific items or services required under subsection L of this section.
42 The insurer shall retain the affidavit for the duration of the group
43 disability policy and any renewals of the policy. This subsection shall
44 not exclude coverage for prescription contraceptive methods ordered by a
45 health care provider with prescriptive authority for medical indications

1 other than for contraceptive, abortifacient, abortion or sterilization
2 purposes. A religiously affiliated employer offering the policy may state
3 religious beliefs in its affidavit and may require the insured to first
4 pay for the prescription and then submit a claim to the insurer along with
5 evidence that the prescription is not for a purpose covered by the
6 objection. An insurer may charge an administrative fee for handling these
7 claims.

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

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

16 P. For the purposes of:

17 1. This section:

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

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

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

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

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

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

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

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

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

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

7 (e) "SUPPLEMENTAL BREAST EXAMINATION" MEANS A MEDICALLY NECESSARY
8 AND APPROPRIATE EXAMINATION OF THE BREAST THAT USES BREAST MAGNETIC
9 RESONANCE IMAGING, BREAST ULTRASOUND OR BREAST PRESSURE ELASTOGRAPHY WHEN
10 COMBINED WITH A POINT OF CARE ULTRASOUND FOR EVALUATING IDENTIFIED
11 ABNORMALITIES AND THAT IS:

12 (i) USED TO SCREEN FOR BREAST CANCER WHEN AN ABNORMALITY IS NOT
13 SEEN OR SUSPECTED.

14 (ii) BASED ON PERSONAL OR FAMILY MEDICAL HISTORY, ADDITIONAL
15 FACTORS THAT MAY INCREASE A PATIENT'S RISK OF BREAST CANCER OR THE
16 PATIENT'S PERSONAL CHOICE FOR A REGULAR BREAST EXAMINATION, WITH THE
17 FREQUENCY OF THE EXAMINATION DETERMINED BY THE PATIENT AND THE PATIENT'S
18 PHYSICIAN.

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

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

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

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

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

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

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

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

38 20-1404. Blanket disability insurance; definitions

39 A. Blanket disability insurance is that form of disability
40 insurance covering special groups of persons as enumerated in one of the
41 following paragraphs:

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

1 2. Under a policy or contract issued to an employer, who shall be
2 deemed the policyholder, covering all employees or any group of employees
3 defined by reference to hazards incident to an activity or activities or
4 operations of the policyholder. Dependents of the employees and guests of
5 the employer or employees may also be included where exposed to the same
6 hazards.

7 3. Under a policy or contract issued to a college, school or other
8 institution of learning or to the head or principal thereof, who or which
9 shall be deemed the policyholder, covering students, teachers, employees
10 or volunteers.

11 4. Under a policy or contract issued in the name of any volunteer
12 fire department or any first aid, civil defense or other such volunteer
13 group, or agency having jurisdiction thereof, which shall be deemed the
14 policyholder, covering all or any group of the members, participants or
15 volunteers of the fire department or first aid, civil defense or other
16 group.

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

19 6. Under a policy or contract issued to a sports team or to a camp
20 or sponsor thereof, which team or camp or sponsor thereof shall be deemed
21 the policyholder, covering members, campers, employees, officials,
22 supervisors or volunteers.

23 7. Under a policy or contract issued to an incorporated or
24 unincorporated religious, charitable, recreational, educational or civic
25 organization, or branch thereof, which organization shall be deemed the
26 policyholder, covering any group of members, participants or volunteers
27 defined by reference to hazards incident to an activity or activities or
28 operations sponsored or supervised by or on the premises of the
29 policyholder.

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

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

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

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

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

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

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

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

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

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

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

37 E. Any policy or contract, except accidental death and
38 dismemberment, applied for that provides family coverage, as to such
39 coverage of family members, shall also provide that the benefits
40 applicable for children shall be payable with respect to a newly born
41 child of the insured from the instant of such child's birth, to a child
42 adopted by the insured, regardless of the age at which the child was
43 adopted, and to a child who has been placed for adoption with the insured
44 and for whom the application and approval procedures for adoption pursuant
45 to section 8-105 or 8-108 have been completed to the same extent that such

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

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

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

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

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

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

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

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

39 1. A mammogram.

40 2. 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 **3. A SUPPLEMENTAL BREAST EXAMINATION.**

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

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

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

10 3. All preexisting conditions and other limitations have been met
11 by the insured.

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

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

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

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

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

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

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

4 5. Except as described in subsection L 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 L. Subsection K of this section does not:

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

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

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

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

24 1. Blood glucose monitors.

25 2. Blood glucose monitors for the legally blind.

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

28 4. Insulin preparations and glucagon.

29 5. Insulin cartridges.

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

31 7. Injection aids.

32 8. Insulin cartridges for the legally blind.

33 9. Syringes and lancets including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

19 Q. Any contract that is offered by a blanket 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 R. 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 S. 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 T. An insurer shall cover at least fifty percent of the cost of
43 medical foods prescribed to treat inherited metabolic disorders and
44 covered pursuant to this section. An insurer may limit the maximum annual
45 benefit for medical foods under this section to \$5,000, which applies to

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

3 U. Any blanket 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 blanket disability
7 insurer may use a drug formulary, multitiered drug formulary or list but
8 that formulary or list shall include oral, implant and injectable
9 contraceptive drugs, intrauterine devices and prescription barrier
10 methods. The blanket disability insurer may not impose deductibles,
11 coinsurance, copayments or other cost containment measures for
12 contraceptive drugs that are greater than the deductibles, coinsurance,
13 copayments or other cost containment measures for other drugs on the same
14 level of the formulary or list.

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

21 V. Notwithstanding subsection U of this section, a religiously
22 affiliated employer may require that the insurer provide a blanket
23 disability policy without coverage for specific items or services required
24 under subsection U 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 U 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 blanket disability policy that excludes coverage for
32 specific items or services required under subsection U of this section.
33 The insurer shall retain the affidavit for the duration of the blanket
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 under this subsection.

1 W. Subsection V 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 X. Subsection V 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 Y. 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 (e) "SUPPLEMENTAL BREAST EXAMINATION" MEANS A MEDICALLY NECESSARY
2 AND APPROPRIATE EXAMINATION OF THE BREAST THAT USES BREAST MAGNETIC
3 RESONANCE IMAGING, BREAST ULTRASOUND OR BREAST PRESSURE ELASTOGRAPHY WHEN
4 COMBINED WITH A POINT OF CARE ULTRASOUND FOR EVALUATING IDENTIFIED
5 ABNORMALITIES AND THAT IS:

6 (i) USED TO SCREEN FOR BREAST CANCER WHEN AN ABNORMALITY IS NOT
7 SEEN OR SUSPECTED.

8 (ii) BASED ON PERSONAL OR FAMILY MEDICAL HISTORY, ADDITIONAL
9 FACTORS THAT MAY INCREASE A PATIENT'S RISK OF BREAST CANCER OR THE
10 PATIENT'S PERSONAL CHOICE FOR A REGULAR BREAST EXAMINATION, WITH THE
11 FREQUENCY OF THE EXAMINATION DETERMINED BY THE PATIENT AND THE PATIENT'S
12 PHYSICIAN.

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

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

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

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

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

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

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

30 Sec. 6. Section 36-2907, Arizona Revised Statutes, is amended to
31 read:

32 36-2907. Covered health and medical services; modifications;
33 related delivery of service requirements; rules;
34 definition

35 A. Subject to the limits and exclusions specified in this section,
36 contractors shall provide the following medically necessary health and
37 medical services:

38 1. Inpatient hospital services that are ordinarily furnished by a
39 hospital to care FOR and treat inpatients and that are provided under the
40 direction of a physician or a primary care practitioner. For the purposes
41 of this section, inpatient hospital services exclude services in an
42 institution for tuberculosis or mental diseases unless authorized under an
43 approved section 1115 waiver.

44 2. Outpatient health services that are ordinarily provided in
45 hospitals, clinics, offices and other health care facilities by licensed

1 health care providers. Outpatient health services include services
2 provided by or under the direction of a physician or a primary care
3 practitioner, including occupational therapy.

4 3. Other laboratory and X-ray services ordered by a physician or a
5 primary care practitioner.

6 4. Medications that are ordered on prescription by a physician or a
7 dentist who is licensed pursuant to title 32, chapter 11. Persons who are
8 dually eligible for title XVIII and title XIX services must obtain
9 available medications through a medicare licensed or certified medicare
10 advantage prescription drug plan, a medicare prescription drug plan or any
11 other entity authorized by medicare to provide a medicare part D
12 prescription drug benefit.

13 5. Medical supplies, durable medical equipment, insulin pumps and
14 prosthetic devices ordered by a physician or a primary care practitioner.
15 Suppliers of durable medical equipment shall provide the administration
16 with complete information about the identity of each person who has an
17 ownership or controlling interest in their business and shall comply with
18 federal bonding requirements in a manner prescribed by the administration.

19 6. For persons who are at least twenty-one years of age, treatment
20 of medical conditions of the eye, excluding eye examinations for
21 prescriptive lenses and the provision of prescriptive lenses.

22 7. Early and periodic health screening and diagnostic services as
23 required by section 1905(r) of title XIX of the social security act for
24 members who are under twenty-one years of age.

25 8. Family planning services that do not include abortion or
26 abortion counseling. If a contractor elects not to provide family
27 planning services, this election does not disqualify the contractor from
28 delivering all other covered health and medical services under this
29 chapter. In that event, the administration may contract directly with
30 another contractor, including an outpatient surgical center or a
31 noncontracting provider, to deliver family planning services to a member
32 who is enrolled with the contractor that elects not to provide family
33 planning services.

34 9. Podiatry services that are performed by a podiatrist who is
35 licensed pursuant to title 32, chapter 7 and ordered by a primary care
36 physician or primary care practitioner.

37 10. Nonexperimental transplants approved for title XIX
38 reimbursement.

39 11. Dental services as follows:

40 (a) Except as provided in subdivision (b) of this paragraph, for
41 persons who are at least twenty-one years of age, emergency dental care
42 and extractions in an annual amount of not more than \$1,000 per member.

43 (b) Subject to approval by the centers for medicare and medicaid
44 services, for persons treated at an Indian health service or tribal
45 facility, adult dental services that are eligible for a federal medical

1 assistance percentage of one hundred percent and that exceed the limit
2 prescribed in subdivision (a) of this paragraph.

3 12. Ambulance and nonambulance transportation, except as provided
4 in subsection G of this section.

5 13. Hospice care.

6 14. Orthotics, if all of the following apply:

7 (a) The use of the orthotic is medically necessary as the preferred
8 treatment option consistent with medicare guidelines.

9 (b) The orthotic is less expensive than all other treatment options
10 or surgical procedures to treat the same diagnosed condition.

11 (c) The orthotic is ordered by a physician or primary care
12 practitioner.

13 15. Subject to approval by the centers for medicare and medicaid
14 services, medically necessary chiropractic services that are performed by
15 a chiropractor who is licensed pursuant to title 32, chapter 8 and that
16 are ordered by a primary care physician or primary care practitioner
17 pursuant to rules adopted by the administration. The primary care
18 physician or primary care practitioner may initially order up to twenty
19 visits annually that include treatment and may request authorization for
20 additional chiropractic services in that same year if additional
21 chiropractic services are medically necessary.

22 16. For up to ten program hours annually, diabetes outpatient
23 self-management training services, as defined in 42 United States Code
24 section 1395x, if prescribed by a primary care practitioner in either of
25 the following circumstances:

26 (a) The member is initially diagnosed with diabetes.

27 (b) For a member who has previously been diagnosed with diabetes,
28 either:

29 (i) A change occurs in the member's diagnosis, medical condition or
30 treatment regimen.

31 (ii) The member is not meeting appropriate clinical outcomes.

32 17. SUBJECT TO APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID
33 SERVICES, WELL-WOMAN PREVENTATIVE CARE SERVICES THAT INCLUDE A REFERRAL
34 FOR A SEPARATE BREAST EXAMINATION USING A HIGH-RESOLUTION PRESSURE
35 ELASTOGRAPHY DEVICE, IF THE EXAMINATION INCLUDES IMMEDIATE POINT-OF-CARE
36 ULTRASOUND OF ANY IDENTIFIED POTENTIAL ABNORMALITIES BASED ON AN INCREASED
37 RISK OF BREAST CANCER, THE PROVIDER'S RECOMMENDATION OVER TRADITIONAL
38 CLINICAL BREAST EXAMINATION OR A WOMAN'S PERSONAL PREFERENCE.

39 B. The limits and exclusions for health and medical services
40 provided under this section are as follows:

41 1. Circumcision of newborn males is not a covered health and
42 medical service.

43 2. For eligible persons who are at least twenty-one years of age:

44 (a) Outpatient health services do not include speech therapy.

1 (b) Prosthetic devices do not include hearing aids, dentures,
2 bone-anchored hearing aids or cochlear implants. Prosthetic devices,
3 except prosthetic implants, may be limited to \$12,500 per contract year.

4 (c) Percussive vests are not covered health and medical services.

5 (d) Durable medical equipment is limited to items covered by
6 medicare.

7 (e) Nonexperimental transplants do not include pancreas-only
8 transplants.

9 (f) Bariatric surgery procedures, including laparoscopic and open
10 gastric bypass and restrictive procedures, are not covered health and
11 medical services.

12 C. The system shall pay noncontracting providers only for health
13 and medical services as prescribed in subsection A of this section and as
14 prescribed by rule.

15 D. The director shall adopt rules necessary to limit, to the extent
16 possible, the scope, duration and amount of services, including maximum
17 limits for inpatient services that are consistent with federal regulations
18 under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42
19 United States Code section 1396 (1980)). To the extent possible and
20 practicable, these rules shall provide for the prior approval of medically
21 necessary services provided pursuant to this chapter.

22 E. The director shall make available home health services in lieu
23 of hospitalization pursuant to contracts awarded under this article. For
24 the purposes of this subsection, "home health services" means the
25 provision of nursing services, home health aide services or medical
26 supplies, equipment and appliances that are provided on a part-time or
27 intermittent basis by a licensed home health agency within a member's
28 residence based on the orders of a physician or a primary care
29 practitioner. Home health agencies shall comply with the federal bonding
30 requirements in a manner prescribed by the administration.

31 F. The director shall adopt rules for the coverage of behavioral
32 health services for persons who are eligible under section 36-2901,
33 paragraph 6, subdivision (a). The administration acting through the
34 regional behavioral health authorities shall establish a diagnostic and
35 evaluation program to which other state agencies shall refer children who
36 are not already enrolled pursuant to this chapter and who may be in need
37 of behavioral health services. In addition to an evaluation, the
38 administration acting through regional behavioral health authorities shall
39 also identify children who may be eligible under section 36-2901,
40 paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall
41 refer the children to the appropriate agency responsible for making the
42 final eligibility determination.

43 G. The director shall adopt rules providing for transportation
44 services and rules providing for copayment by members for transportation
45 for other than emergency purposes. Subject to approval by the centers for

1 medicare and medicaid services, nonemergency medical transportation shall
2 not be provided except for stretcher vans and ambulance transportation.
3 Prior authorization is required for transportation by stretcher van and
4 for medically necessary ambulance transportation initiated pursuant to a
5 physician's direction. Prior authorization is not required for medically
6 necessary ambulance transportation services rendered to members or
7 eligible persons initiated by dialing telephone number 911 or other
8 designated emergency response systems.

9 H. The director may adopt rules to allow the administration, at the
10 director's discretion, to use a second opinion procedure under which
11 surgery may not be eligible for coverage pursuant to this chapter without
12 documentation as to need by at least two physicians or primary care
13 practitioners.

14 I. If the director does not receive bids within the amounts
15 budgeted or if at any time the amount remaining in the Arizona health care
16 cost containment system fund is insufficient to pay for full contract
17 services for the remainder of the contract term, the administration, on
18 notification to system contractors at least thirty days in advance, may
19 modify the list of services required under subsection A of this section
20 for persons defined as eligible other than those persons defined pursuant
21 to section 36-2901, paragraph 6, subdivision (a). The director may also
22 suspend services or may limit categories of expense for services defined
23 as optional pursuant to title XIX of the social security act (P.L. 89-97;
24 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons
25 defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such
26 reductions or suspensions do not apply to the continuity of care for
27 persons already receiving these services.

28 J. All health and medical services provided under this article
29 shall be provided in the geographic service area of the member, except:

30 1. Emergency services and specialty services provided pursuant to
31 section 36-2908.

32 2. That the director may allow the delivery of health and medical
33 services in other than the geographic service area in this state or in an
34 adjoining state if the director determines that medical practice patterns
35 justify the delivery of services or a net reduction in transportation
36 costs can reasonably be expected. Notwithstanding the definition of
37 physician as prescribed in section 36-2901, if services are procured from
38 a physician or primary care practitioner in an adjoining state, the
39 physician or primary care practitioner shall be licensed to practice in
40 that state pursuant to licensing statutes in that state that are similar
41 to title 32, chapter 13, 15, 17 or 25 and shall complete a provider
42 agreement for this state.

43 K. Covered outpatient services shall be subcontracted by a primary
44 care physician or primary care practitioner to other licensed health care
45 providers to the extent practicable for purposes including, but not

1 limited to, making health care services available to underserved areas,
2 reducing costs of providing medical care and reducing transportation
3 costs.

4 L. The director shall adopt rules that prescribe the coordination
5 of medical care for persons who are eligible for system services. The
6 rules shall include provisions for transferring patients and medical
7 records and initiating medical care.

8 M. Notwithstanding section 36-2901.08, monies from the hospital
9 assessment fund established by section 36-2901.09 may not be used to
10 provide **EITHER OF THE FOLLOWING:**

11 1. Chiropractic services as prescribed in subsection A, paragraph
12 15 of this section.

13 ~~N. Notwithstanding section 36-2901.08, monies from the hospital~~
14 ~~assessment fund established by section 36-2901.09 may not be used to~~
15 ~~provide~~

16 2. Diabetes outpatient self-management training services as
17 prescribed in subsection A, paragraph 16 of this section.

18 ~~0.~~ N. For the purposes of this section, "ambulance" has the same
19 meaning prescribed in section 36-2201.

20 Sec. 7. Short title

21 This act may be cited as the "Ysabel Act".