REFERENCE TITLE: supplemental breast exams; insurance; coverage

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Senate
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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)

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

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

20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

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

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

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

G. A corporation may not cancel or refuse to renew any subscriber's contract without giving notice of such cancellation or nonrenewal to the subscriber under such contract. A notice by the corporation to the subscriber of cancellation or nonrenewal of a subscription contract shall be mailed to the named subscriber at least forty-five days before the effective date of such cancellation or nonrenewal. The notice shall include or be accompanied by a statement in writing of the reasons for such action by the corporation. Failure of the corporation to comply with this subsection shall invalidate any cancellation or nonrenewal except a cancellation or nonrenewal for nonpayment of premium.

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

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

1. A mammogram.

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

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

3. A SUPPLEMENTAL BREAST EXAMINATION.

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

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

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

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

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

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

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

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

1. Conditions of eligibility.

2. Coverage of dependents.

3. Preexisting conditions.

4. Termination of insurance.

5. Probationary periods.

6. Limitations.

7. Exceptions.

8. Reductions.

9. Elimination periods.

10. Requirements for replacement.

11. Any other condition of subscription contracts.

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

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

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

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

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

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

O. Subsection N of this section does not:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets, including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

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

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

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

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

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

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

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

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

CC. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. A mammogram.

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

3. A SUPPLEMENTAL BREAST EXAMINATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. Any other conditions of evidences of coverage.

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

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.
2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.
3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.
4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.
5. Except as described in subsection S of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

S. Subsection R of this section does not:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

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

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

U. Subsection T of this section does not:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

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

DD. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20-1342. Scope and format of policy; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) A mammogram.

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

(c) A SUPPLEMENTAL BREAST EXAMINATION.

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

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

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

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

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

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

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

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

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

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

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

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

C. Subsection B of this section does not:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

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

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

E. Subsection D of this section does not:

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32,

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

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

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

L. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20-1402. Provisions of group disability policies; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) A mammogram.

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

(c) A SUPPLEMENTAL BREAST EXAMINATION.

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

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

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

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

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

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

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

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

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

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

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

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

C. Subsection B of this section does not:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

L. Any group disability policy that provides coverage for:

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

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

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

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

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

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

P. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. A mammogram.

2. Digital breast tomosynthesis, magnetic resonance imaging, ultrasound or other modality and at such age and intervals as recommended by the national comprehensive cancer network. This includes patients at risk for breast cancer who have a family history with one or more first or second degree relatives with breast cancer, prior diagnosis of breast cancer, positive testing for hereditary gene mutations or heterogeneously

or dense breast tissue based on the breast imaging reporting and data system of the American college of radiology.

3. A SUPPLEMENTAL BREAST EXAMINATION.

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

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

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

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

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

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

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

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

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

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

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

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

L. Subsection K of this section does not:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

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

U. Any blanket disability policy that provides coverage for:

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

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

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

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

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

Y. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Nonexperimental transplants approved for title XIX reimbursement.

11. Dental services as follows:

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

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

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

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

13. Hospice care.

14. Orthotics, if all of the following apply:

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

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

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

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

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

(a) The member is initially diagnosed with diabetes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Short title

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