REFERENCE TITLE: health insurance coverage; insulin

State of Arizona
Senate
Fifty-sixth Legislature
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2024

SB 1438

Introduced by
Senator Gabaldón

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1402, 20-1404 AND 20-2325, ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:
2 Section 1. Section 20-826, Arizona Revised Statutes, is amended to
3 read:
4 20-826. Subscription contracts; definitions
5 A. A contract between a corporation and its subscribers shall not
6 be issued unless the form of such contract is approved in writing by the
7 director.
8 B. Each contract shall plainly state the services to which the
9 subscriber is entitled and those to which the subscriber is not entitled
10 under the plan, and shall constitute a direct obligation of the providers
11 of services with which the corporation has contracted for hospital,
12 medical, dental or optometric services.
13 C. Each contract, except for dental services or optometric
14 services, shall be so written that the corporation shall pay benefits for
15 each of the following:
16 1. Performance of any surgical service that is covered by the terms
17 of such contract, regardless of the place of service.
18 2. Any home health services that are performed by a licensed home
19 health agency and that a physician has prescribed in lieu of hospital
20 services, as defined by the director, providing the hospital services
21 would have been covered.
22 3. Any diagnostic service that a physician has performed outside a
23 hospital in lieu of inpatient service, providing the inpatient service
24 would have been covered.
25 4. Any service performed in a hospital's outpatient department or
26 in a freestanding surgical facility, if such service would have been
27 covered if performed as an inpatient service.
28 D. Each contract for dental or optometric services shall be so
29 written that the corporation shall pay benefits for contracted dental or
30 optometric services provided by dentists or optometrists.
31 E. Any contract, except accidental death and dismemberment, applied
32 for that provides family coverage, as to such coverage of family members,
33 shall also provide that the benefits applicable for children shall be
34 payable with respect to a newly born child of the insured from the instant
35 of such child's birth, to a child adopted by the insured, regardless of
36 the age at which the child was adopted, and to a child who has been placed
37 for adoption with the insured and for whom the application and approval
38 procedures for adoption pursuant to section 8-105 or 8-108 have been
39 completed to the same extent that such coverage applies to other members
40 of the family. The coverage for newly born or adopted children or
41 children placed for adoption shall include coverage of injury or sickness,
42 including necessary care and treatment of medically diagnosed congenital
43 defects and birth abnormalities. If payment of a specific premium is
44 required to provide coverage for a child, the contract may require that
45 notification of birth, adoption or adoption placement of the child and

1 payment of the required premium must be furnished to the insurer within
2 thirty-one days after the date of birth, adoption or adoption placement in
3 order to have the coverage continue beyond the thirty-one day period.
4 F. Each contract that is delivered or issued for delivery in this
5 state after December 25, 1977 and that provides that coverage of a
6 dependent child shall terminate on attainment of the limiting age for
7 dependent children specified in the contract shall also provide in
8 substance that attainment of such limiting age shall not operate to
9 terminate the coverage of such child while the child is and continues to
10 be both incapable of self-sustaining employment by reason of intellectual
11 disability or physical disability and chiefly dependent on the subscriber
12 for support and maintenance. Proof of such incapacity and dependency
13 shall be furnished to the corporation by the subscriber within thirty-one
14 days of the child's attainment of the limiting age and subsequently as may
15 be required by the corporation, but not more frequently than annually
16 after the two-year period following the child's attainment of the limiting
17 age.
18 G. A corporation may not cancel or refuse to renew any subscriber's
19 contract without giving notice of such cancellation or nonrenewal to the
20 subscriber under such contract. A notice by the corporation to the
21 subscriber of cancellation or nonrenewal of a subscription contract shall
22 be mailed to the named subscriber at least forty-five days before the
23 effective date of such cancellation or nonrenewal. The notice shall
24 include or be accompanied by a statement in writing of the reasons for
25 such action by the corporation. Failure of the corporation to comply with
26 this subsection shall invalidate any cancellation or nonrenewal except a
27 cancellation or nonrenewal for nonpayment of premium.
28 H. A contract that provides coverage for surgical services for a
29 mastectomy shall also provide coverage incidental to the patient's covered
30 mastectomy for surgical services for reconstruction of the breast on which
31 the mastectomy was performed, surgery and reconstruction of the other
32 breast to produce a symmetrical appearance, prostheses, treatment of
33 physical complications for all stages of the mastectomy, including
34 lymphedemas, and at least two external postoperative prostheses subject to
35 all of the terms and conditions of the policy.
36 I. A contract that provides coverage for surgical services for a
37 mastectomy shall also provide coverage for preventive mammography
38 screening and diagnostic imaging performed on dedicated equipment for
39 diagnostic purposes on referral by a patient's physician, subject to all
40 of the terms and conditions of the policy, including:
41 1. A mammogram.
42 2. Digital breast tomosynthesis, magnetic resonance imaging,
43 ultrasound or other modality and at such age and intervals as recommended
44 by the national comprehensive cancer network. This includes patients at
45 risk for breast cancer who have a family history with one or more first or

1 second degree relatives with breast cancer, prior diagnosis of breast
2 cancer, positive testing for hereditary gene mutations or heterogeneously
3 or dense breast tissue based on the breast imaging reporting and data
4 system of the American college of radiology.
5 J. Any contract that is issued to the insured and that provides
6 coverage for maternity benefits shall also provide that the maternity
7 benefits apply to the costs of the birth of any child legally adopted by
8 the insured if all of the following are true:
9 1. The child is adopted within one year of birth.
10 2. The insured is legally obligated to pay the costs of birth.
11 3. All preexisting conditions and other limitations have been met
12 by the insured.
13 4. The insured has notified the insurer of the insured's
14 acceptability to adopt children pursuant to section 8-105, within sixty
15 days after such approval or within sixty days after a change in insurance
16 policies, plans or companies.
17 K. The coverage prescribed by subsection J of this section is
18 excess to any other coverage the natural mother may have for maternity
19 benefits except coverage made available to persons pursuant to title 36,
20 chapter 29. If such other coverage exists, the agency, attorney or
21 individual arranging the adoption shall make arrangements for the
22 insurance to pay those costs that may be covered under that policy and
23 shall advise the adopting parent in writing of the existence and extent of
24 the coverage without disclosing any confidential information such as the
25 identity of the natural parent. The insured adopting parents shall notify
26 their insurer of the existence and extent of the other coverage.
27 L. The director may disapprove any contract if the benefits
28 provided in the form of such contract are unreasonable in relation to the
29 premium charged.
30 M. The director shall adopt emergency rules applicable to persons
31 who are leaving active service in the armed forces of the United States
32 and returning to civilian status including:
33 1. Conditions of eligibility.
34 2. Coverage of dependents.
35 3. Preexisting conditions.
36 4. Termination of insurance.
37 5. Probationary periods.
38 6. Limitations.
39 7. Exceptions.
40 8. Reductions.
41 9. Elimination periods.
42 10. Requirements for replacement.
43 11. Any other condition of subscription contracts.
44 N. Any contract that provides maternity benefits shall not restrict
45 benefits for any hospital length of stay in connection with childbirth for

1 the mother or the newborn child to less than forty-eight hours following a
2 normal vaginal delivery or ninety-six hours following a cesarean section.
3 The contract shall not require the provider to obtain authorization from
4 the corporation for prescribing the minimum length of stay required by
5 this subsection. The contract may provide that an attending provider in
6 consultation with the mother may discharge the mother or the newborn child
7 before the expiration of the minimum length of stay required by this
8 subsection. The corporation shall not:
9 1. Deny the mother or the newborn child eligibility or continued
10 eligibility to enroll or to renew coverage under the terms of the contract
11 solely for the purpose of avoiding the requirements of this subsection.
12 2. Provide monetary payments or rebates to mothers to encourage
13 those mothers to accept less than the minimum protections available
14 pursuant to this subsection.
15 3. Penalize or otherwise reduce or limit the reimbursement of an
16 attending provider because that provider provided care to any insured
17 under the contract in accordance with this subsection.
18 4. Provide monetary or other incentives to an attending provider to
19 induce that provider to provide care to an insured under the contract in a
20 manner that is inconsistent with this subsection.
21 5. Except as described in subsection O of this section, restrict
22 benefits for any portion of a period within the minimum length of stay in
23 a manner that is less favorable than the benefits provided for any
24 preceding portion of that stay.
25 O. Subsection N of this section does not:
26 1. Require a mother to give birth in a hospital or to stay in the
27 hospital for a fixed period of time following the birth of the child.
28 2. Prevent a corporation from imposing deductibles, coinsurance or
29 other cost sharing in relation to benefits for hospital lengths of stay in
30 connection with childbirth for a mother or a newborn child under the
31 contract, except that any coinsurance or other cost sharing for any
32 portion of a period within a hospital length of stay required pursuant to
33 subsection N of this section shall not be greater than the coinsurance or
34 cost sharing for any preceding portion of that stay.
35 3. Prevent a corporation from negotiating the level and type of
36 reimbursement with a provider for care provided in accordance with
37 subsection N of this section.
38 P. Any contract that provides coverage for diabetes shall also
39 provide coverage for equipment and supplies that are medically necessary
40 and that are prescribed by a health care provider, including:
41 1. Blood glucose monitors.
42 2. Blood glucose monitors for the legally blind.
43 3. Test strips for glucose monitors and visual reading and urine
44 testing strips.
45 4. Insulin preparations and glucagon.

1 5. Insulin cartridges.
2 6. Drawing up devices and monitors for the visually impaired.
3 7. Injection aids.
4 8. Insulin cartridges for the legally blind.
5 9. Syringes and lancets, including automatic lancing devices.
6 10. Prescribed oral agents for controlling blood sugar that are
7 included on the plan formulary.
8 11. To the extent coverage is required under medicare, podiatric
9 appliances for prevention of complications associated with diabetes.
10 12. Any other device, medication, equipment or supply for which
11 coverage is required under medicare from and after January 1, 1999. The
12 coverage required in this paragraph is effective six months after the
13 coverage is required under medicare.
14 Q. Subsection P of this section does not prohibit a medical service
15 corporation, a hospital service corporation or a hospital, medical, dental
16 and optometric service corporation from imposing deductibles, coinsurance
17 or other cost sharing in relation to benefits for equipment or supplies
18 for the treatment of diabetes, EXCEPT THAT A MEDICAL SERVICE CORPORATION,
19 A HOSPITAL SERVICE CORPORATION OR A HOSPITAL, MEDICAL, DENTAL AND
20 OPTOMETRIC SERVICE CORPORATION SHALL LIMIT THE TOTAL AMOUNT THAT A
21 SUBSCRIBER MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE
22 THAN $35 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR
23 TYPE OF INSULIN REQUIRED TO FILL THE SUBSCRIBER'S PRESCRIPTION. FOR THE
24 PURPOSES OF THIS SUBSECTION, "PRESCRIPTION INSULIN DRUG" MEANS ANY
25 PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED
26 BY A HEALTH CARE PROFESSIONAL TO A SUBSCRIBER TO TREAT THE SUBSCRIBER'S
27 CONDITION, THAT CONTAINS INSULIN AND THAT IS USED TO TREAT DIABETES.
28 R. Any hospital or medical service contract that provides coverage
29 for prescription drugs shall not limit or exclude coverage for any
30 prescription drug prescribed for the treatment of cancer on the basis that
31 the prescription drug has not been approved by the United States food and
32 drug administration for the treatment of the specific type of cancer for
33 which the prescription drug has been prescribed, if the prescription drug
34 has been recognized as safe and effective for treatment of that specific
35 type of cancer in one or more of the standard medical reference compendia
36 prescribed in subsection S of this section or medical literature that
37 meets the criteria prescribed in subsection S of this section. The
38 coverage required under this subsection includes covered medically
39 necessary services associated with the administration of the prescription
40 drug. This subsection does not:
41 1. Require coverage of any prescription drug used in the treatment
42 of a type of cancer if the United States food and drug administration has
43 determined that the prescription drug is contraindicated for that type of
44 cancer.

1 2. Require coverage for any experimental prescription drug that is
2 not approved for any indication by the United States food and drug
3 administration.
4 3. Alter any law with regard to provisions that limit the coverage
5 of prescription drugs that have not been approved by the United States
6 food and drug administration.
7 4. Notwithstanding section 20-841.05, require reimbursement or
8 coverage for any prescription drug that is not included in the drug
9 formulary or list of covered prescription drugs specified in the contract.
10 5. Notwithstanding section 20-841.05, prohibit a contract from
11 limiting or excluding coverage of a prescription drug, if the decision to
12 limit or exclude coverage of the prescription drug is not based primarily
13 on the coverage of prescription drugs required by this section.
14 6. Prohibit the use of deductibles, coinsurance, copayments or
15 other cost sharing in relation to drug benefits and related medical
16 benefits offered.
17 S. For the purposes of subsection R of this section:
18 1. The acceptable standard medical reference compendia are the
19 following:
20 (a) The American hospital formulary service drug information, a
21 publication of the American society of health system pharmacists.
22 (b) The national comprehensive cancer network drugs and biologics
23 compendium.
24 (c) Thomson Micromedex compendium DrugDex.
25 (d) Elsevier gold standard's clinical pharmacology compendium.
26 (e) Other authoritative compendia as identified by the secretary of
27 the United States department of health and human services.
28 2. Medical literature may be accepted if all of the following
29 apply:
30 (a) At least two articles from major peer reviewed professional
31 medical journals have recognized, based on scientific or medical criteria,
32 the drug's safety and effectiveness for treatment of the indication for
33 which the drug has been prescribed.
34 (b) No article from a major peer reviewed professional medical
35 journal has concluded, based on scientific or medical criteria, that the
36 drug is unsafe or ineffective or that the drug's safety and effectiveness
37 cannot be determined for the treatment of the indication for which the
38 drug has been prescribed.
39 (c) The literature meets the uniform requirements for manuscripts
40 submitted to biomedical journals established by the international
41 committee of medical journal editors or is published in a journal
42 specified by the United States department of health and human services as
43 acceptable peer reviewed medical literature pursuant to section
44 186(t)(2)(B) of the social security act (42 United States Code section
45 1395x(t)(2)(B)).

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.

1 W. Medical foods eligible for coverage under this section shall be
2 prescribed or ordered under the supervision of a physician licensed
3 pursuant to title 32, chapter 13 or 17 as medically necessary for the
4 therapeutic treatment of an inherited metabolic disease.
5 X. A hospital service corporation or medical service corporation
6 shall cover at least fifty percent of the cost of medical foods prescribed
7 to treat inherited metabolic disorders and covered pursuant to this
8 section. A hospital service corporation or medical service corporation
9 may limit the maximum annual benefit for medical foods under this section
10 to $5,000, which applies to the cost of all prescribed modified low
11 protein foods and metabolic formula.
12 Y. Any contract between a corporation and its subscribers is
13 subject to the following:
14 1. If the contract provides coverage for prescription drugs, the
15 contract shall provide coverage for any prescribed drug or device that is
16 approved by the United States food and drug administration for use as a
17 contraceptive. A corporation may use a drug formulary, multitiered drug
18 formulary or list but that formulary or list shall include oral, implant
19 and injectable contraceptive drugs, intrauterine devices and prescription
20 barrier methods. The corporation may not impose deductibles,
21 coinsurance, copayments or other cost containment measures for
22 contraceptive drugs that are greater than the deductibles, coinsurance,
23 copayments or other cost containment measures for other drugs on the same
24 level of the formulary or list.
25 2. If the contract provides coverage for outpatient health care
26 services, the contract shall provide coverage for outpatient contraceptive
27 services. For the purposes of this paragraph, "outpatient contraceptive
28 services" means consultations, examinations, procedures and medical
29 services provided on an outpatient basis and related to the use of
30 approved United States food and drug administration prescription
31 contraceptive methods to prevent unintended pregnancies.
32 3. This subsection does not apply to contracts issued to
33 individuals on a nongroup basis.
34 Z. Notwithstanding subsection Y of this section, a religiously
35 affiliated employer may require that the corporation provide a contract
36 without coverage for specific items or services required under subsection
37 Y of this section because providing or paying for coverage of the specific
38 items or services is contrary to the religious beliefs of the religiously
39 affiliated employer offering the plan. If a religiously affiliated
40 employer objects to providing coverage for specific items or services
41 required under subsection Y of this section, a written affidavit shall be
42 filed with the corporation stating the objection. On receipt of the
43 affidavit, the corporation shall issue to the religiously affiliated
44 employer a contract that excludes coverage for specific items or services
45 required under subsection Y of this section. The corporation shall retain

1 the affidavit for the duration of the contract and any renewals of the
2 contract. This subsection shall not exclude coverage for prescription
3 contraceptive methods ordered by a health care provider with prescriptive
4 authority for medical indications other than for contraceptive,
5 abortifacient, abortion or sterilization purposes. A religiously
6 affiliated employer offering the plan may state religious beliefs in its
7 affidavit and may require the subscriber to first pay for the prescription
8 and then submit a claim to the hospital service corporation, medical
9 service corporation or hospital, medical, dental and optometric service
10 corporation along with evidence that the prescription is not for a purpose
11 covered by the objection. A hospital service corporation, medical service
12 corporation or hospital, medical, dental and optometric service
13 corporation may charge an administrative fee for handling these claims.
14 AA. Subsection Z of this section does not authorize a religiously
15 affiliated employer to obtain an employee's protected health information
16 or to violate the health insurance portability and accountability act of
17 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
18 pursuant to that act.
19 BB. Subsection Z of this section does not restrict or limit any
20 protections against employment discrimination that are prescribed in
21 federal or state law.
22 CC. For the purposes of:
23 1. This section:
24 (a) "Inherited metabolic disorder" means a disease caused by an
25 inherited abnormality of body chemistry and includes a disease tested
26 under the newborn screening program prescribed in section 36-694.
27 (b) "Medical foods" means modified low protein foods and metabolic
28 formula.
29 (c) "Metabolic formula" means foods that are all of the following:
30 (i) Formulated to be consumed or administered enterally under the
31 supervision of a physician who is licensed pursuant to title 32, chapter
32 13 or 17.
33 (ii) Processed or formulated to be deficient in one or more of the
34 nutrients present in typical foodstuffs.
35 (iii) Administered for the medical and nutritional management of a
36 person who has limited capacity to metabolize foodstuffs or certain
37 nutrients contained in the foodstuffs or who has other specific nutrient
38 requirements as established by medical evaluation.
39 (iv) Essential to a person's optimal growth, health and metabolic
40 homeostasis.
41 (d) "Modified low protein foods" means foods that are all of the
42 following:
43 (i) Formulated to be consumed or administered enterally under the
44 supervision of a physician who is licensed pursuant to title 32, chapter
45 13 or 17.

1 (ii) Processed or formulated to contain less than one gram of
2 protein per unit of serving, but does not include a natural food that is
3 naturally low in protein.
4 (iii) Administered for the medical and nutritional management of a
5 person who has limited capacity to metabolize foodstuffs or certain
6 nutrients contained in the foodstuffs or who has other specific nutrient
7 requirements as established by medical evaluation.
8 (iv) Essential to a person's optimal growth, health and metabolic
9 homeostasis.
10 2. Subsection E of this section, "child", for purposes of initial
11 coverage of an adopted child or a child placed for adoption but not for
12 purposes of termination of coverage of such child, means a person who is
13 under eighteen years of age.
14 3. Subsections Z and AA of this section, "religiously affiliated
15 employer" means either:
16 (a) An entity for which all of the following apply:
17 (i) The entity primarily employs persons who share the religious
18 tenets of the entity.
19 (ii) The entity primarily serves persons who share the religious
20 tenets of the entity.
21 (iii) The entity is a nonprofit organization as described in
22 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as
23 amended.
24 (b) An entity whose articles of incorporation clearly state that it
25 is a religiously motivated organization and whose religious beliefs are
26 central to the organization's operating principles.
27 Sec. 2. Section 20-1057, Arizona Revised Statutes, is amended to
28 read:
29 20-1057. Evidence of coverage by health care services
30 organizations; renewability; definitions
31 A. Every enrollee in a health care plan shall be issued an evidence
32 of coverage by the responsible health care services organization.
33 B. Any contract, except accidental death and dismemberment, applied
34 for that provides family coverage shall also provide, as to such coverage
35 of family members, that the benefits applicable for children shall be
36 payable with respect to a newly born child of the enrollee from the
37 instant of such child's birth, to a child adopted by the enrollee,
38 regardless of the age at which the child was adopted, and to a child who
39 has been placed for adoption with the enrollee and for whom the
40 application and approval procedures for adoption pursuant to section 8-105
41 or 8-108 have been completed to the same extent that such coverage applies
42 to other members of the family. The coverage for newly born or adopted
43 children or children placed for adoption shall include coverage of injury
44 or sickness including necessary care and treatment of medically diagnosed
45 congenital defects and birth abnormalities. If payment of a specific

1 premium is required to provide coverage for a child, the contract may
2 require that notification of birth, adoption or adoption placement of the
3 child and payment of the required premium must be furnished to the insurer
4 within thirty-one days after the date of birth, adoption or adoption
5 placement in order to have the coverage continue beyond the thirty-one day
6 period.
7 C. Any contract, except accidental death and dismemberment, that
8 provides coverage for psychiatric, drug abuse or alcoholism services shall
9 require the health care services organization to provide reimbursement for
10 those services in accordance with the terms of the contract without regard
11 to whether the covered services are rendered in a psychiatric special
12 hospital or general hospital.
13 D. An evidence of coverage or amendment to the coverage shall not
14 be issued or delivered to any person in this state until a copy of the
15 form of the evidence of coverage or amendment to the coverage has been
16 filed with and approved by the director.
17 E. An evidence of coverage shall contain a clear and complete
18 statement if a contract, or a reasonably complete summary if a certificate
19 of contract, of:
20 1. The health care services and the insurance or other benefits, if
21 any, to which the enrollee is entitled under the health care plan.
22 2. Any limitations of the services, kind of services, benefits or
23 kind of benefits to be provided, including any deductible or copayment
24 feature.
25 3. Where and in what manner information is available as to how
26 services may be obtained.
27 4. The enrollee's obligation, if any, respecting charges for the
28 health care plan.
29 F. An evidence of coverage shall not contain provisions or
30 statements that are unjust, unfair, inequitable, misleading or deceptive,
31 that encourage misrepresentation or that are untrue.
32 G. The director shall approve any form of evidence of coverage if
33 the requirements of subsections E and F of this section are met. It is
34 unlawful to issue such form until approved. If the director does not
35 disapprove any such form within forty-five days after the filing of the
36 form, it is deemed approved. If the director disapproves a form of
37 evidence of coverage, the director shall notify the health care services
38 organization. In the notice, the director shall specify the reasons for
39 the director's disapproval. The director shall grant a hearing on such
40 disapproval within fifteen days after a request for a hearing in writing
41 is received from the health care services organization.
42 H. A health care services organization shall not cancel or refuse
43 to renew an enrollee's evidence of coverage that was issued on a group
44 basis without giving notice of the cancellation or nonrenewal to the
45 enrollee and, on request of the director, to the department of insurance

1 and financial institutions. A notice by the organization to the enrollee
2 of cancellation or nonrenewal of the enrollee's evidence of coverage shall
3 be mailed to the enrollee at least sixty days before the effective date of
4 such cancellation or nonrenewal. The notice shall include or be
5 accompanied by a statement in writing of the reasons as stated in the
6 contract for such action by the organization. Failure of the organization
7 to comply with this subsection shall invalidate any cancellation or
8 nonrenewal except a cancellation or nonrenewal for nonpayment of premium,
9 for fraud or misrepresentation in the application or other enrollment
10 documents or for loss of eligibility as defined in the evidence of
11 coverage. A health care services organization shall not cancel an
12 enrollee's evidence of coverage issued on a group basis because of the
13 enrollee's or dependent's age, except for loss of eligibility as defined
14 in the evidence of coverage, sex, health status-related factor, national
15 origin or frequency of utilization of health care services of the
16 enrollee. An evidence of coverage issued on a group basis shall clearly
17 delineate all terms under which the health care services organization may
18 cancel or refuse to renew an evidence of coverage for an enrollee or
19 dependent. ~~Nothing in~~ This subsection ~~prohibits~~ DOES NOT PROHIBIT the
20 cancellation or nonrenewal of a health benefits plan contract issued on a
21 group basis for any of the reasons allowed in section 20-2309. A health
22 care services organization may cancel or nonrenew an evidence of coverage
23 issued to an individual on a nongroup basis only for the reasons allowed
24 by subsection N of this section.
25 I. A health care plan that provides coverage for surgical services
26 for a mastectomy shall also provide coverage incidental to the patient's
27 covered mastectomy for surgical services for reconstruction of the breast
28 on which the mastectomy was performed, surgery and reconstruction of the
29 other breast to produce a symmetrical appearance, prostheses, treatment of
30 physical complications for all stages of the mastectomy, including
31 lymphedemas, and at least two external postoperative prostheses subject to
32 all of the terms and conditions of the policy.
33 J. A contract that provides coverage for surgical services for a
34 mastectomy shall also provide coverage for preventive mammography
35 screening and diagnostic imaging performed on dedicated equipment for
36 diagnostic purposes on referral by a patient's physician, subject to all
37 of the terms and conditions of the policy, including:
38 1. A mammogram.
39 2. Digital breast tomosynthesis, magnetic resonance imaging,
40 ultrasound or other modality and at such age and intervals as recommended
41 by the national comprehensive cancer network. This includes patients at
42 risk for breast cancer who have a family history with one or more first or
43 second degree relatives with breast cancer, prior diagnosis of breast
44 cancer, positive testing for hereditary gene mutations or heterogeneously

1 or dense breast tissue based on the breast imaging reporting and data
2 system of the American college of radiology.
3 K. Any contract that is issued to the enrollee and that provides
4 coverage for maternity benefits shall also provide that the maternity
5 benefits apply to the costs of the birth of any child legally adopted by
6 the enrollee if all the following are true:
7 1. The child is adopted within one year of birth.
8 2. The enrollee is legally obligated to pay the costs of birth.
9 3. All preexisting conditions and other limitations have been met
10 and all deductibles and copayments have been paid by the enrollee.
11 4. The enrollee has notified the insurer of the enrollee's
12 acceptability to adopt children pursuant to section 8-105 within sixty
13 days after such approval or within sixty days after a change in insurance
14 policies, plans or companies.
15 L. The coverage prescribed by subsection K of this section is
16 excess to any other coverage the natural mother may have for maternity
17 benefits except coverage made available to persons pursuant to title 36,
18 chapter 29. If such other coverage exists the agency, attorney or
19 individual arranging the adoption shall make arrangements for the
20 insurance to pay those costs that may be covered under that policy and
21 shall advise the adopting parent in writing of the existence and extent of
22 the coverage without disclosing any confidential information such as the
23 identity of the natural parent. The enrollee adopting parents shall
24 notify their health care services organization of the existence and extent
25 of the other coverage. A health care services organization is not
26 required to pay any costs in excess of the amounts it would have been
27 obligated to pay to its hospitals and providers if the natural mother and
28 child had received the maternity and newborn care directly from or through
29 that health care services organization.
30 M. Each health care services organization shall offer membership to
31 the following in a conversion plan that provides the basic health care
32 benefits required by the director:
33 1. Each enrollee including the enrollee's enrolled dependents
34 leaving a group.
35 2. Each enrollee and the enrollee's dependents who would otherwise
36 cease to be eligible for membership because of the age of the enrollee or
37 the enrollee's dependents or the death or the dissolution of marriage of
38 an enrollee.
39 N. A health care services organization shall not cancel or nonrenew
40 an evidence of coverage issued to an individual on a nongroup basis,
41 including a conversion plan, except for any of the following reasons and
42 in compliance with the notice and disclosure requirements contained in
43 subsection H of this section:
44 1. The individual has failed to pay premiums or contributions in
45 accordance with the terms of the evidence of coverage or the health care

1 services organization has not received premium payments in a timely
2 manner.
3 2. The individual has performed an act or practice that constitutes
4 fraud or the individual made an intentional misrepresentation of material
5 fact under the terms of the evidence of coverage.
6 3. The health care services organization has ceased to offer
7 coverage to individuals that is consistent with the requirements of
8 sections 20-1379 and 20-1380.
9 4. If the health care services organization offers a health care
10 plan in this state through a network plan, the individual no longer
11 resides, lives or works in the service area served by the network plan or
12 in an area for which the health care services organization is authorized
13 to transact business but only if the coverage is terminated uniformly
14 without regard to any health status-related factor of the covered
15 individual.
16 5. If the health care services organization offers health coverage
17 in this state in the individual market only through one or more bona fide
18 associations, the membership of the individual in the association has
19 ceased but only if that coverage is terminated uniformly without regard to
20 any health status-related factor of any covered individual.
21 O. A conversion plan may be modified if the modification complies
22 with the notice and disclosure provisions for cancellation and nonrenewal
23 under subsection H of this section. A modification of a conversion plan
24 that has already been issued shall not result in the effective elimination
25 of any benefit originally included in the conversion plan.
26 P. Any person who is a United States armed forces reservist, who is
27 ordered to active military duty on or after August 22, 1990 and who was
28 enrolled in a health care plan shall have the right to reinstate such
29 coverage on release from active military duty subject to the following
30 conditions:
31 1. The reservist shall make written application to the health plan
32 within ninety days of discharge from active military duty or within one
33 year of hospitalization continuing after discharge. Coverage shall be
34 effective on receipt of the application by the health plan.
35 2. The health plan may exclude from such coverage any health or
36 physical condition arising during and occurring as a direct result of
37 active military duty.
38 Q. The director shall adopt emergency rules that are applicable to
39 persons who are leaving active service in the armed forces of the United
40 States and returning to civilian status consistent with subsection P of
41 this section and that include:
42 1. Conditions of eligibility.
43 2. Coverage of dependents.
44 3. Preexisting conditions.
45 4. Termination of insurance.

1 5. Probationary periods.
2 6. Limitations.
3 7. Exceptions.
4 8. Reductions.
5 9. Elimination periods.
6 10. Requirements for replacement.
7 11. Any other conditions of evidences of coverage.
8 R. Any contract that provides maternity benefits shall not restrict
9 benefits for any hospital length of stay in connection with childbirth for
10 the mother or the newborn child to less than forty-eight hours following a
11 normal vaginal delivery or ninety-six hours following a cesarean section.
12 The contract shall not require the provider to obtain authorization from
13 the health care services organization for prescribing the minimum length
14 of stay required by this subsection. The contract may provide that an
15 attending provider in consultation with the mother may discharge the
16 mother or the newborn child before the expiration of the minimum length of
17 stay required by this subsection. The health care services organization
18 shall not:
19 1. Deny the mother or the newborn child eligibility or continued
20 eligibility to enroll or to renew coverage under the terms of the contract
21 solely for the purpose of avoiding the requirements of this subsection.
22 2. Provide monetary payments or rebates to mothers to encourage
23 those mothers to accept less than the minimum protections available
24 pursuant to this subsection.
25 3. Penalize or otherwise reduce or limit the reimbursement of an
26 attending provider because that provider provided care to any insured
27 under the contract in accordance with this subsection.
28 4. Provide monetary or other incentives to an attending provider to
29 induce that provider to provide care to an insured under the contract in a
30 manner that is inconsistent with this subsection.
31 5. Except as described in subsection S of this section, restrict
32 benefits for any portion of a period within the minimum length of stay in
33 a manner that is less favorable than the benefits provided for any
34 preceding portion of that stay.
35 S. Subsection R of this section does not:
36 1. Require a mother to give birth in a hospital or to stay in the
37 hospital for a fixed period of time following the birth of the child.
38 2. Prevent a health care services organization from imposing
39 deductibles, coinsurance or other cost sharing in relation to benefits for
40 hospital lengths of stay in connection with childbirth for a mother or a
41 newborn child under the contract, except that any coinsurance or other
42 cost sharing for any portion of a period within a hospital length of stay
43 required pursuant to subsection R of this section shall not be greater
44 than the coinsurance or cost sharing for any preceding portion of that
45 stay.

1 3. Prevent a health care services organization from negotiating the
2 level and type of reimbursement with a provider for care provided in
3 accordance with subsection R of this section.
4 T. Any contract or evidence of coverage that provides coverage for
5 diabetes shall also provide coverage for equipment and supplies that are
6 medically necessary and that are prescribed by a health care provider
7 including:
8 1. Blood glucose monitors.
9 2. Blood glucose monitors for the legally blind.
10 3. Test strips for glucose monitors and visual reading and urine
11 testing strips.
12 4. Insulin preparations and glucagon.
13 5. Insulin cartridges.
14 6. Drawing up devices and monitors for the visually impaired.
15 7. Injection aids.
16 8. Insulin cartridges for the legally blind.
17 9. Syringes and lancets including automatic lancing devices.
18 10. Prescribed oral agents for controlling blood sugar that are
19 included on the plan formulary.
20 11. To the extent coverage is required under medicare, podiatric
21 appliances for prevention of complications associated with diabetes.
22 12. Any other device, medication, equipment or supply for which
23 coverage is required under medicare from and after January 1, 1999. The
24 coverage required in this paragraph is effective six months after the
25 coverage is required under medicare.
26 U. Subsection T of this section does not:
27 1. Entitle a member or enrollee of a health care services
28 organization to equipment or supplies for the treatment of diabetes that
29 are not medically necessary as determined by the health care services
30 organization medical director or the medical director's designee.
31 2. Provide coverage for diabetic supplies obtained by a member or
32 enrollee of a health care services organization without a prescription
33 unless otherwise allowed pursuant to the terms of the health care plan.
34 3. Prohibit a health care services organization from imposing
35 deductibles, coinsurance or other cost sharing in relation to benefits for
36 equipment or supplies for the treatment of diabetes, EXCEPT THAT A HEALTH
37 CARE SERVICES CORPORATION SHALL LIMIT THE TOTAL AMOUNT THAT A MEMBER OR
38 ENROLLEE MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN
39 $35 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF
40 INSULIN REQUIRED TO FILL THE MEMBER'S OR ENROLLEE'S PRESCRIPTION. FOR THE
41 PURPOSES OF THIS PARAGRAPH, "PRESCRIPTION INSULIN DRUG" MEANS ANY
42 PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED
43 BY A HEALTH CARE PROFESSIONAL TO A MEMBER OR ENROLLEE TO TREAT THE MEMBER
44 OR ENROLLEE CONDITION, THAT CONTAINS INSULIN AND THAT IS USED TO TREAT
45 DIABETES.

1 V. Any contract or evidence of coverage that provides coverage for
2 prescription drugs shall not limit or exclude coverage for any
3 prescription drug prescribed for the treatment of cancer on the basis that
4 the prescription drug has not been approved by the United States food and
5 drug administration for the treatment of the specific type of cancer for
6 which the prescription drug has been prescribed, if the prescription drug
7 has been recognized as safe and effective for treatment of that specific
8 type of cancer in one or more of the standard medical reference compendia
9 prescribed in subsection W of this section or medical literature that
10 meets the criteria prescribed in subsection W of this section. The
11 coverage required under this subsection includes covered medically
12 necessary services associated with the administration of the prescription
13 drug. This subsection does not:
14 1. Require coverage of any prescription drug used in the treatment
15 of a type of cancer if the United States food and drug administration has
16 determined that the prescription drug is contraindicated for that type of
17 cancer.
18 2. Require coverage for any experimental prescription drug that is
19 not approved for any indication by the United States food and drug
20 administration.
21 3. Alter any law with regard to provisions that limit the coverage
22 of prescription drugs that have not been approved by the United States
23 food and drug administration.
24 4. Notwithstanding section 20-1057.02, require reimbursement or
25 coverage for any prescription drug that is not included in the drug
26 formulary or list of covered prescription drugs specified in the contract
27 or evidence of coverage.
28 5. Notwithstanding section 20-1057.02, prohibit a contract or
29 evidence of coverage from limiting or excluding coverage of a prescription
30 drug, if the decision to limit or exclude coverage of the prescription
31 drug is not based primarily on the coverage of prescription drugs required
32 by this section.
33 6. Prohibit the use of deductibles, coinsurance, copayments or
34 other cost sharing in relation to drug benefits and related medical
35 benefits offered.
36 W. For the purposes of subsection V of this section:
37 1. The acceptable standard medical reference compendia are the
38 following:
39 (a) The American hospital formulary service drug information, a
40 publication of the American society of health system pharmacists.
41 (b) The national comprehensive cancer network drugs and biologics
42 compendium.
43 (c) Thomson Micromedex compendium DrugDex.
44 (d) Elsevier gold standard's clinical pharmacology compendium.

1 (e) Other authoritative compendia as identified by the secretary of
2 the United States department of health and human services.
3 2. Medical literature may be accepted if all of the following
4 apply:
5 (a) At least two articles from major peer reviewed professional
6 medical journals have recognized, based on scientific or medical criteria,
7 the drug's safety and effectiveness for treatment of the indication for
8 which the drug has been prescribed.
9 (b) No article from a major peer reviewed professional medical
10 journal has concluded, based on scientific or medical criteria, that the
11 drug is unsafe or ineffective or that the drug's safety and effectiveness
12 cannot be determined for the treatment of the indication for which the
13 drug has been prescribed.
14 (c) The literature meets the uniform requirements for manuscripts
15 submitted to biomedical journals established by the international
16 committee of medical journal editors or is published in a journal
17 specified by the United States department of health and human services as
18 acceptable peer reviewed medical literature pursuant to section
19 186(t)(2)(B) of the social security act (42 United States Code section
20 1395x(t)(2)(B)).
21 X. A health care services organization shall not issue or deliver
22 any advertising matter or sales material to any person in this state until
23 the health care services organization files the advertising matter or
24 sales material with the director. This subsection does not require a
25 health care services organization to have the prior approval of the
26 director to issue or deliver the advertising matter or sales material. If
27 the director finds that the advertising matter or sales material, in whole
28 or in part, is false, deceptive or misleading, the director may issue an
29 order disapproving the advertising matter or sales material, directing the
30 health care services organization to cease and desist from issuing,
31 circulating, displaying or using the advertising matter or sales material
32 within a period of time specified by the director but not less than ten
33 days and imposing any penalties prescribed in this title. At least five
34 days before issuing an order pursuant to this subsection, the director
35 shall provide the health care services organization with a written notice
36 of the basis of the order to provide the health care services organization
37 with an opportunity to cure the alleged deficiency in the advertising
38 matter or sales material within a single five-day period for the
39 particular advertising matter or sales material at issue. The health care
40 services organization may appeal the director's order pursuant to title
41 41, chapter 6, article 10. Except as otherwise provided in this
42 subsection, a health care services organization may obtain a stay of the
43 effectiveness of the order as prescribed in section 20-162. If the
44 director certifies in the order and provides a detailed explanation of the
45 reasons in support of the certification that continued use of the

1 advertising matter or sales material poses a threat to the health, safety
2 or welfare of the public, the order may be entered immediately without
3 opportunity for cure and the effectiveness of the order is not stayed
4 pending the hearing on the notice of appeal but the hearing shall be
5 promptly instituted and determined.
6 Y. Any contract or evidence of coverage that is offered by a health
7 care services organization and that contains a prescription drug benefit
8 shall provide coverage of medical foods to treat inherited metabolic
9 disorders as provided by this section.
10 Z. The metabolic disorders triggering medical foods coverage under
11 this section shall:
12 1. Be part of the newborn screening program prescribed in section
13 36-694.
14 2. Involve amino acid, carbohydrate or fat metabolism.
15 3. Have medically standard methods of diagnosis, treatment and
16 monitoring including quantification of metabolites in blood, urine or
17 spinal fluid or enzyme or DNA confirmation in tissues.
18 4. Require specially processed or treated medical foods that are
19 generally available only under the supervision and direction of a
20 physician who is licensed pursuant to title 32, chapter 13 or 17 or a
21 registered nurse practitioner who is licensed pursuant to title 32,
22 chapter 15, that must be consumed throughout life and without which the
23 person may suffer serious mental or physical impairment.
24 AA. Medical foods eligible for coverage under this section shall be
25 prescribed or ordered under the supervision of a physician licensed
26 pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner
27 who is licensed pursuant to title 32, chapter 15 as medically necessary
28 for the therapeutic treatment of an inherited metabolic disease.
29 BB. A health care services organization shall cover at least fifty
30 percent of the cost of medical foods prescribed to treat inherited
31 metabolic disorders and covered pursuant to this section. An organization
32 may limit the maximum annual benefit for medical foods under this section
33 to $5,000, which applies to the cost of all prescribed modified low
34 protein foods and metabolic formula.
35 CC. Unless preempted under federal law or unless federal law
36 imposes greater requirements than this section, this section applies to a
37 provider sponsored health care services organization.
38 DD. For the purposes of:
39 1. This section:
40 (a) "Inherited metabolic disorder" means a disease caused by an
41 inherited abnormality of body chemistry and includes a disease tested
42 under the newborn screening program prescribed in section 36-694.
43 (b) "Medical foods" means modified low protein foods and metabolic
44 formula.

1 (c) "Metabolic formula" means foods that are all of the following:
2 (i) Formulated to be consumed or administered enterally under the
3 supervision of a physician who is licensed pursuant to title 32, chapter
4 13 or 17 or a registered nurse practitioner who is licensed pursuant to
5 title 32, chapter 15.
6 (ii) Processed or formulated to be deficient in one or more of the
7 nutrients present in typical foodstuffs.
8 (iii) Administered for the medical and nutritional management of a
9 person who has limited capacity to metabolize foodstuffs or certain
10 nutrients contained in the foodstuffs or who has other specific nutrient
11 requirements as established by medical evaluation.
12 (iv) Essential to a person's optimal growth, health and metabolic
13 homeostasis.
14 (d) "Modified low protein foods" means foods that are all of the
15 following:
16 (i) Formulated to be consumed or administered enterally under the
17 supervision of a physician who is licensed pursuant to title 32, chapter
18 13 or 17 or a registered nurse practitioner who is licensed pursuant to
19 title 32, chapter 15.
20 (ii) Processed or formulated to contain less than one gram of
21 protein per unit of serving, but does not include a natural food that is
22 naturally low in protein.
23 (iii) Administered for the medical and nutritional management of a
24 person who has limited capacity to metabolize foodstuffs or certain
25 nutrients contained in the foodstuffs or who has other specific nutrient
26 requirements as established by medical evaluation.
27 (iv) Essential to a person's optimal growth, health and metabolic
28 homeostasis.
29 2. Subsection B of this section, "child", for purposes of initial
30 coverage of an adopted child or a child placed for adoption but not for
31 purposes of termination of coverage of such child, means a person who is
32 under eighteen years of age.
33 Sec. 3. Section 20-1342, Arizona Revised Statutes, is amended to
34 read:
35 20-1342. Scope and format of policy; definitions
36 A. A policy of disability insurance shall not be delivered or
37 issued for delivery to any person in this state unless it otherwise
38 complies with this title and complies with the following:
39 1. The entire money and other considerations shall be expressed in
40 the policy.
41 2. The time when the insurance takes effect and terminates shall be
42 expressed in the policy.
43 3. It shall purport to insure only one person, except that a policy
44 may insure, originally or by subsequent amendment, on the application of
45 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.

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.

1 2. Prevent an insurer from imposing deductibles, coinsurance or
2 other cost sharing in relation to benefits for hospital lengths of stay in
3 connection with childbirth for a mother or a newborn child under the
4 contract, except that any coinsurance or other cost sharing for any
5 portion of a period within a hospital length of stay required pursuant to
6 subsection B of this section shall not be greater than the coinsurance or
7 cost sharing for any preceding portion of that stay.
8 3. Prevent an insurer from negotiating the level and type of
9 reimbursement with a provider for care provided in accordance with
10 subsection B of this section.
11 D. Any contract that provides coverage for diabetes shall also
12 provide coverage for equipment and supplies that are medically necessary
13 and that are prescribed by a health care provider including:
14 1. Blood glucose monitors.
15 2. Blood glucose monitors for the legally blind.
16 3. Test strips for glucose monitors and visual reading and urine
17 testing strips.
18 4. Insulin preparations and glucagon.
19 5. Insulin cartridges.
20 6. Drawing up devices and monitors for the visually impaired.
21 7. Injection aids.
22 8. Insulin cartridges for the legally blind.
23 9. Syringes and lancets including automatic lancing devices.
24 10. Prescribed oral agents for controlling blood sugar that are
25 included on the plan formulary.
26 11. To the extent coverage is required under medicare, podiatric
27 appliances for prevention of complications associated with diabetes.
28 12. Any other device, medication, equipment or supply for which
29 coverage is required under medicare from and after January 1, 1999. The
30 coverage required in this paragraph is effective six months after the
31 coverage is required under medicare.
32 E. Subsection D of this section does not:
33 1. Prohibit a disability insurer from imposing deductibles,
34 coinsurance or other cost sharing in relation to benefits for equipment or
35 supplies for the treatment of diabetes, EXCEPT THAT A DISABILITY INSURER
36 SHALL LIMIT THE TOTAL AMOUNT THAT AN INSURED MUST PAY FOR A COVERED
37 PRESCRIPTION INSULIN DRUG TO NOT MORE THAN $35 PER THIRTY-DAY SUPPLY OF
38 INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE
39 INSURED'S PRESCRIPTION. FOR THE PURPOSES OF THIS PARAGRAPH, "PRESCRIPTION
40 INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED IN SECTION
41 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO AN INSURED TO
42 TREAT THE INSURED'S CONDITION, THAT CONTAINS INSULIN AND THAT IS USED TO
43 TREAT DIABETES.

1 2. Require a policy to provide an insured with outpatient benefits
2 if the policy does not cover outpatient benefits.
3 F. Any contract that provides coverage for prescription drugs shall
4 not limit or exclude coverage for any prescription drug prescribed for the
5 treatment of cancer on the basis that the prescription drug has not been
6 approved by the United States food and drug administration for the
7 treatment of the specific type of cancer for which the prescription drug
8 has been prescribed, if the prescription drug has been recognized as safe
9 and effective for treatment of that specific type of cancer in one or more
10 of the standard medical reference compendia prescribed in subsection G of
11 this section or medical literature that meets the criteria prescribed in
12 subsection G of this section. The coverage required under this subsection
13 includes covered medically necessary services associated with the
14 administration of the prescription drug. This subsection does not:
15 1. Require coverage of any prescription drug used in the treatment
16 of a type of cancer if the United States food and drug administration has
17 determined that the prescription drug is contraindicated for that type of
18 cancer.
19 2. Require coverage for any experimental prescription drug that is
20 not approved for any indication by the United States food and drug
21 administration.
22 3. Alter any law with regard to provisions that limit the coverage
23 of prescription drugs that have not been approved by the United States
24 food and drug administration.
25 4. Require reimbursement or coverage for any prescription drug that
26 is not included in the drug formulary or list of covered prescription
27 drugs specified in the contract.
28 5. Prohibit a contract from limiting or excluding coverage of a
29 prescription drug, if the decision to limit or exclude coverage of the
30 prescription drug is not based primarily on the coverage of prescription
31 drugs required by this section.
32 6. Prohibit the use of deductibles, coinsurance, copayments or
33 other cost sharing in relation to drug benefits and related medical
34 benefits offered.
35 G. For the purposes of subsection F of this section:
36 1. The acceptable standard medical reference compendia are the
37 following:
38 (a) The American hospital formulary service drug information, a
39 publication of the American society of health system pharmacists.
40 (b) The national comprehensive cancer network drugs and biologics
41 compendium.
42 (c) Thomson Micromedex compendium DrugDex.
43 (d) Elsevier gold standard's clinical pharmacology compendium.
44 (e) Other authoritative compendia as identified by the secretary of
45 the United States department of health and human services.

1 2. Medical literature may be accepted if all of the following
2 apply:
3 (a) At least two articles from major peer reviewed professional
4 medical journals have recognized, based on scientific or medical criteria,
5 the drug's safety and effectiveness for treatment of the indication for
6 which the drug has been prescribed.
7 (b) No article from a major peer reviewed professional medical
8 journal has concluded, based on scientific or medical criteria, that the
9 drug is unsafe or ineffective or that the drug's safety and effectiveness
10 cannot be determined for the treatment of the indication for which the
11 drug has been prescribed.
12 (c) The literature meets the uniform requirements for manuscripts
13 submitted to biomedical journals established by the international
14 committee of medical journal editors or is published in a journal
15 specified by the United States department of health and human services as
16 acceptable peer reviewed medical literature pursuant to section
17 186(t)(2)(B) of the social security act (42 United States Code section
18 1395x(t)(2)(B)).
19 H. Any contract that is offered by a disability insurer and that
20 contains a routine outpatient prescription drug benefit shall provide
21 coverage of medical foods to treat inherited metabolic disorders as
22 provided by this section.
23 I. The metabolic disorders triggering medical foods coverage under
24 this section shall:
25 1. Be part of the newborn screening program prescribed in section
26 36-694.
27 2. Involve amino acid, carbohydrate or fat metabolism.
28 3. Have medically standard methods of diagnosis, treatment and
29 monitoring including quantification of metabolites in blood, urine or
30 spinal fluid or enzyme or DNA confirmation in tissues.
31 4. Require specially processed or treated medical foods that are
32 generally available only under the supervision and direction of a
33 physician who is licensed pursuant to title 32, chapter 13 or 17 or a
34 registered nurse practitioner who is licensed pursuant to title 32,
35 chapter 15, that must be consumed throughout life and without which the
36 person may suffer serious mental or physical impairment.
37 J. Medical foods eligible for coverage under this section shall be
38 prescribed or ordered under the supervision of a physician licensed
39 pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner
40 who is licensed pursuant to title 32, chapter 15 as medically necessary
41 for the therapeutic treatment of an inherited metabolic disease.
42 K. An insurer shall cover at least fifty percent of the cost of
43 medical foods prescribed to treat inherited metabolic disorders and
44 covered pursuant to this section. An insurer may limit the maximum annual
45 benefit for medical foods under this section to $5,000, which applies to

1 the cost of all prescribed modified low protein foods and metabolic
2 formula.
3 L. For the purposes of:
4 1. This section:
5 (a) "Inherited metabolic disorder" means a disease caused by an
6 inherited abnormality of body chemistry and includes a disease tested
7 under the newborn screening program prescribed in section 36-694.
8 (b) "Medical foods" means modified low protein foods and metabolic
9 formula.
10 (c) "Metabolic formula" means foods that are all of the following:
11 (i) Formulated to be consumed or administered enterally under the
12 supervision of a physician who is licensed pursuant to title 32, chapter
13 13 or 17 or a registered nurse practitioner who is licensed pursuant to
14 title 32, chapter 15.
15 (ii) Processed or formulated to be deficient in one or more of the
16 nutrients present in typical foodstuffs.
17 (iii) Administered for the medical and nutritional management of a
18 person who has limited capacity to metabolize foodstuffs or certain
19 nutrients contained in the foodstuffs or who has other specific nutrient
20 requirements as established by medical evaluation.
21 (iv) Essential to a person's optimal growth, health and metabolic
22 homeostasis.
23 (d) "Modified low protein foods" means foods that are all of the
24 following:
25 (i) Formulated to be consumed or administered enterally under the
26 supervision of a physician who is licensed pursuant to title 32, chapter
27 13 or 17 or a registered nurse practitioner who is licensed pursuant to
28 title 32, chapter 15.
29 (ii) Processed or formulated to contain less than one gram of
30 protein per unit of serving, but does not include a natural food that is
31 naturally low in protein.
32 (iii) Administered for the medical and nutritional management of a
33 person who has limited capacity to metabolize foodstuffs or certain
34 nutrients contained in the foodstuffs or who has other specific nutrient
35 requirements as established by medical evaluation.
36 (iv) Essential to a person's optimal growth, health and metabolic
37 homeostasis.
38 2. Subsection A of this section, ~~the term~~ "child", for purposes of
39 initial coverage of an adopted child or a child placed for adoption but
40 not for purposes of termination of coverage of such child, means a person
41 who is under eighteen years of age.

1 Sec. 4. Section 20-1402, Arizona Revised Statutes, is amended to
2 read:
3 20-1402. Provisions of group disability policies; definitions
4 A. Each group disability policy shall contain in substance the
5 following provisions:
6 1. A provision that, in the absence of fraud, all statements made
7 by the policyholder or by any insured person shall be deemed
8 representations and not warranties, and that no statement made for the
9 purpose of effecting insurance shall avoid such insurance or reduce
10 benefits unless contained in a written instrument signed by the
11 policyholder or the insured person, a copy of which has been furnished to
12 the policyholder or to the person or beneficiary.
13 2. A provision that the insurer will furnish to the policyholder,
14 for delivery to each employee or member of the insured group, an
15 individual certificate setting forth in summary form a statement of the
16 essential features of the insurance coverage of the employee or member and
17 to whom benefits are payable. If dependents or family members are
18 included in the coverage additional certificates need not be issued for
19 delivery to the dependents or family members. Any policy, except
20 accidental death and dismemberment, applied for that provides family
21 coverage, as to such coverage of family members, shall also provide that
22 the benefits applicable for children shall be payable with respect to a
23 newly born child of the insured from the instant of such child's birth, to
24 a child adopted by the insured, regardless of the age at which the child
25 was adopted, and to a child who has been placed for adoption with the
26 insured and for whom the application and approval procedures for adoption
27 pursuant to section 8-105 or 8-108 have been completed to the same extent
28 that such coverage applies to other members of the family. The coverage
29 for newly born or adopted children or children placed for adoption shall
30 include coverage of injury or sickness including the necessary care and
31 treatment of medically diagnosed congenital defects and birth
32 abnormalities. If payment of a specific premium is required to provide
33 coverage for a child, the policy may require that notification of birth,
34 adoption or adoption placement of the child and payment of the required
35 premium must be furnished to the insurer within thirty-one days after the
36 date of birth, adoption or adoption placement in order to have the
37 coverage continue beyond such thirty-one day period.
38 3. A provision that to the group originally insured may be added
39 from time to time eligible new employees or members or dependents, as the
40 case may be, in accordance with the terms of the policy.
41 4. Each contract shall be so written that the corporation shall pay
42 benefits:
43 (a) For performance of any surgical service that is covered by the
44 terms of such contract, regardless of the place of service.

1 (b) For any home health services that are performed by a licensed
2 home health agency and that a physician has prescribed in lieu of hospital
3 services, as defined by the director, providing the hospital services
4 would have been covered.
5 (c) For any diagnostic service that a physician has performed
6 outside a hospital in lieu of inpatient service, providing the inpatient
7 service would have been covered.
8 (d) For any service performed in a hospital's outpatient department
9 or in a freestanding surgical facility, providing such service would have
10 been covered if performed as an inpatient service.
11 5. A group disability insurance policy that provides coverage for
12 the surgical expense of a mastectomy shall also provide coverage
13 incidental to the patient's covered mastectomy for the expense of
14 reconstructive surgery of the breast on which the mastectomy was
15 performed, surgery and reconstruction of the other breast to produce a
16 symmetrical appearance, prostheses, treatment of physical complications
17 for all stages of the mastectomy, including lymphedemas, and at least two
18 external postoperative prostheses subject to all of the terms and
19 conditions of the policy.
20 6. A contract, except a supplemental contract covering a specified
21 disease or other limited benefits, that provides coverage for surgical
22 services for a mastectomy shall also provide coverage for preventive
23 mammography screening and diagnostic imaging performed on dedicated
24 equipment for diagnostic purposes on referral by a patient's physician,
25 subject to all of the terms and conditions of the policy, including:
26 (a) A mammogram.
27 (b) Digital breast tomosynthesis, magnetic resonance imaging,
28 ultrasound or other modality and at such age and intervals as recommended
29 by the national comprehensive cancer network. This includes patients at
30 risk for breast cancer who have a family history with one or more first or
31 second degree relatives with breast cancer, prior diagnosis of breast
32 cancer, positive testing for hereditary gene mutations or heterogeneously
33 or dense breast tissue based on the breast imaging reporting and data
34 system of the American college of radiology.
35 7. Any contract that is issued to the insured and that provides
36 coverage for maternity benefits shall also provide that the maternity
37 benefits apply to the costs of the birth of any child legally adopted by
38 the insured if all the following are true:
39 (a) The child is adopted within one year of birth.
40 (b) The insured is legally obligated to pay the costs of birth.
41 (c) All preexisting conditions and other limitations have been met
42 by the insured.
43 (d) The insured has notified the insurer of the insured's
44 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

1 of a period within a hospital length of stay required pursuant to
2 subsection B of this section shall not be greater than the coinsurance or
3 cost sharing for any preceding portion of that stay.
4 3. Prevent an insurer from negotiating the level and type of
5 reimbursement with a provider for care provided in accordance with
6 subsection B of this section.
7 D. Any contract that provides coverage for diabetes shall also
8 provide coverage for equipment and supplies that are medically necessary
9 and that are prescribed by a health care provider including:
10 1. Blood glucose monitors.
11 2. Blood glucose monitors for the legally blind.
12 3. Test strips for glucose monitors and visual reading and urine
13 testing strips.
14 4. Insulin preparations and glucagon.
15 5. Insulin cartridges.
16 6. Drawing up devices and monitors for the visually impaired.
17 7. Injection aids.
18 8. Insulin cartridges for the legally blind.
19 9. Syringes and lancets including automatic lancing devices.
20 10. Prescribed oral agents for controlling blood sugar that are
21 included on the plan formulary.
22 11. To the extent coverage is required under medicare, podiatric
23 appliances for prevention of complications associated with diabetes.
24 12. Any other device, medication, equipment or supply for which
25 coverage is required under medicare from and after January 1, 1999. The
26 coverage required in this paragraph is effective six months after the
27 coverage is required under medicare.
28 E. Subsection D of this section does not prohibit a group
29 disability insurer from imposing deductibles, coinsurance or other cost
30 sharing in relation to benefits for equipment or supplies for the
31 treatment of diabetes, EXCEPT THAT A GROUP DISABILITY INSURER SHALL LIMIT
32 THE TOTAL AMOUNT THAT AN INSURED MUST PAY FOR A COVERED PRESCRIPTION
33 INSULIN DRUG TO NOT MORE THAN $35 PER THIRTY-DAY SUPPLY OF INSULIN,
34 REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE INSURED'S
35 PRESCRIPTION. FOR THE PURPOSES OF THIS SUBSECTION, "PRESCRIPTION INSULIN
36 DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT
37 IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO AN INSURED TO TREAT THE
38 INSURED'S CONDITION, THAT CONTAINS INSULIN AND THAT IS USED TO TREAT
39 DIABETES.
40 F. Any contract that provides coverage for prescription drugs shall
41 not limit or exclude coverage for any prescription drug prescribed for the
42 treatment of cancer on the basis that the prescription drug has not been
43 approved by the United States food and drug administration for the
44 treatment of the specific type of cancer for which the prescription drug
45 has been prescribed, if the prescription drug has been recognized as safe

1 and effective for treatment of that specific type of cancer in one or more
2 of the standard medical reference compendia prescribed in subsection G of
3 this section or medical literature that meets the criteria prescribed in
4 subsection G of this section. The coverage required under this subsection
5 includes covered medically necessary services associated with the
6 administration of the prescription drug. This subsection does not:
7 1. Require coverage of any prescription drug used in the treatment
8 of a type of cancer if the United States food and drug administration has
9 determined that the prescription drug is contraindicated for that type of
10 cancer.
11 2. Require coverage for any experimental prescription drug that is
12 not approved for any indication by the United States food and drug
13 administration.
14 3. Alter any law with regard to provisions that limit the coverage
15 of prescription drugs that have not been approved by the United States
16 food and drug administration.
17 4. Require reimbursement or coverage for any prescription drug that
18 is not included in the drug formulary or list of covered prescription
19 drugs specified in the contract.
20 5. Prohibit a contract from limiting or excluding coverage of a
21 prescription drug, if the decision to limit or exclude coverage of the
22 prescription drug is not based primarily on the coverage of prescription
23 drugs required by this section.
24 6. Prohibit the use of deductibles, coinsurance, copayments or
25 other cost sharing in relation to drug benefits and related medical
26 benefits offered.
27 G. For the purposes of subsection F of this section:
28 1. The acceptable standard medical reference compendia are the
29 following:
30 (a) The American hospital formulary service drug information, a
31 publication of the American society of health system pharmacists.
32 (b) The national comprehensive cancer network drugs and biologics
33 compendium.
34 (c) Thomson Micromedex compendium DrugDex.
35 (d) Elsevier gold standard's clinical pharmacology compendium.
36 (e) Other authoritative compendia as identified by the secretary of
37 the United States department of health and human services.
38 2. Medical literature may be accepted if all of the following
39 apply:
40 (a) At least two articles from major peer reviewed professional
41 medical journals have recognized, based on scientific or medical criteria,
42 the drug's safety and effectiveness for treatment of the indication for
43 which the drug has been prescribed.
44 (b) No article from a major peer reviewed professional medical
45 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

1 contraceptive drugs, intrauterine devices and prescription barrier
2 methods. The group disability insurer may not impose deductibles,
3 coinsurance, copayments or other cost containment measures for
4 contraceptive drugs that are greater than the deductibles, coinsurance,
5 copayments or other cost containment measures for other drugs on the same
6 level of the formulary or list.
7 2. Outpatient health care services shall also provide coverage for
8 outpatient contraceptive services. For the purposes of this paragraph,
9 "outpatient contraceptive services" means consultations, examinations,
10 procedures and medical services provided on an outpatient basis and
11 related to the use of approved United States food and drug administration
12 prescription contraceptive methods to prevent unintended pregnancies.
13 M. Notwithstanding subsection L of this section, a religiously
14 affiliated employer may require that the insurer provide a group
15 disability policy without coverage for specific items or services required
16 under subsection L of this section because providing or paying for
17 coverage of the specific items or services is contrary to the religious
18 beliefs of the religiously affiliated employer offering the plan. If a
19 religiously affiliated employer objects to providing coverage for specific
20 items or services required under subsection L of this section, a written
21 affidavit shall be filed with the insurer stating the objection. On
22 receipt of the affidavit, the insurer shall issue to the religiously
23 affiliated employer a group disability policy that excludes coverage for
24 specific items or services required under subsection L of this section.
25 The insurer shall retain the affidavit for the duration of the group
26 disability policy and any renewals of the policy. This subsection shall
27 not exclude coverage for prescription contraceptive methods ordered by a
28 health care provider with prescriptive authority for medical indications
29 other than for contraceptive, abortifacient, abortion or sterilization
30 purposes. A religiously affiliated employer offering the policy may state
31 religious beliefs in its affidavit and may require the insured to first
32 pay for the prescription and then submit a claim to the insurer along with
33 evidence that the prescription is not for a purpose covered by the
34 objection. An insurer may charge an administrative fee for handling these
35 claims.
36 N. Subsection M of this section does not authorize a religiously
37 affiliated employer to obtain an employee's protected health information
38 or to violate the health insurance portability and accountability act of
39 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
40 pursuant to that act.
41 O. Subsection M of this section shall not be construed to restrict
42 or limit any protections against employment discrimination that are
43 prescribed in federal or state law.

P. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (ii) The entity serves primarily persons who share the religious
2 tenets of the entity.
3 (iii) The entity is a nonprofit organization as described in
4 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as
5 amended.
6 (b) An entity whose articles of incorporation clearly state that it
7 is a religiously motivated organization and whose religious beliefs are
8 central to the organization's operating principles.
9 Sec. 5. Section 20-1404, Arizona Revised Statutes, is amended to
10 read:
11 20-1404. Blanket disability insurance; definitions
12 A. Blanket disability insurance is that form of disability
13 insurance covering special groups of persons as enumerated in one of the
14 following paragraphs:
15 1. Under a policy or contract issued to any common carrier or to
16 any operator, owner or lessee of a means of transportation, which shall be
17 deemed the policyholder, covering a group defined as all persons who may
18 become passengers on such common carrier or means of transportation.
19 2. Under a policy or contract issued to an employer, who shall be
20 deemed the policyholder, covering all employees or any group of employees
21 defined by reference to hazards incident to an activity or activities or
22 operations of the policyholder. Dependents of the employees and guests of
23 the employer or employees may also be included where exposed to the same
24 hazards.
25 3. Under a policy or contract issued to a college, school or other
26 institution of learning or to the head or principal thereof, who or which
27 shall be deemed the policyholder, covering students, teachers, employees
28 or volunteers.
29 4. Under a policy or contract issued in the name of any volunteer
30 fire department or any first aid, civil defense or other such volunteer
31 group, or agency having jurisdiction thereof, which shall be deemed the
32 policyholder, covering all or any group of the members, participants or
33 volunteers of the fire department or first aid, civil defense or other
34 group.
35 5. Under a policy or contract issued to a creditor, who shall be
36 deemed the policyholder, to insure debtors of the creditor.
37 6. Under a policy or contract issued to a sports team or to a camp
38 or sponsor thereof, which team or camp or sponsor thereof shall be deemed
39 the policyholder, covering members, campers, employees, officials,
40 supervisors or volunteers.
41 7. Under a policy or contract issued to an incorporated or
42 unincorporated religious, charitable, recreational, educational or civic
43 organization, or branch thereof, which organization shall be deemed the
44 policyholder, covering any group of members, participants or volunteers
45 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

1 indemnities provided by any such policy on account of hospital, nursing,
2 medical or surgical services, at the insurer's option, may be paid
3 directly to the hospital or person rendering such services, but the policy
4 may not require that the service be rendered by a particular hospital or
5 person. Payment so made shall discharge the insurer's obligation with
6 respect to the amount of insurance so paid.
7 D. This section does not affect the legal liability of
8 policyholders for the death of or injury to any member of the group.
9 E. Any policy or contract, except accidental death and
10 dismemberment, applied for that provides family coverage, as to such
11 coverage of family members, shall also provide that the benefits
12 applicable for children shall be payable with respect to a newly born
13 child of the insured from the instant of such child's birth, to a child
14 adopted by the insured, regardless of the age at which the child was
15 adopted, and to a child who has been placed for adoption with the insured
16 and for whom the application and approval procedures for adoption pursuant
17 to section 8-105 or 8-108 have been completed to the same extent that such
18 coverage applies to other members of the family. The coverage for newly
19 born or adopted children or children placed for adoption shall include
20 coverage of injury or sickness including necessary care and treatment of
21 medically diagnosed congenital defects and birth abnormalities. If
22 payment of a specific premium is required to provide coverage for a child,
23 the policy or contract may require that notification of birth, adoption or
24 adoption placement of the child and payment of the required premium must
25 be furnished to the insurer within thirty-one days after the date of
26 birth, adoption or adoption placement in order to have the coverage
27 continue beyond the thirty-one day period.
28 F. Each policy or contract shall be so written that the insurer
29 shall pay benefits:
30 1. For performance of any surgical service that is covered by the
31 terms of such contract, regardless of the place of service.
32 2. For any home health services that are performed by a licensed
33 home health agency and that a physician has prescribed in lieu of hospital
34 services, as defined by the director, providing the hospital services
35 would have been covered.
36 3. For any diagnostic service that a physician has performed
37 outside a hospital in lieu of inpatient service, providing the inpatient
38 service would have been covered.
39 4. For any service performed in a hospital's outpatient department
40 or in a freestanding surgical facility, providing such service would have
41 been covered if performed as an inpatient service.
42 G. A blanket disability insurance policy that provides coverage for
43 the surgical expense of a mastectomy shall also provide coverage
44 incidental to the patient's covered mastectomy for the expense of
45 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.

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, EXCEPT THAT A BLANKET DISABILITY INSURER SHALL LIMIT THE TOTAL AMOUNT THAT AN INSURED MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN $35 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE INSURED'S PRESCRIPTION. FOR THE PURPOSES OF THIS SUBSECTION, "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO AN INSURED TO TREAT THE INSURED'S CONDITION, THAT CONTAINS INSULIN AND THAT IS USED TO TREAT 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.

1 4. Require reimbursement or coverage for any prescription drug that
2 is not included in the drug formulary or list of covered prescription
3 drugs specified in the contract.
4 5. Prohibit a contract from limiting or excluding coverage of a
5 prescription drug, if the decision to limit or exclude coverage of the
6 prescription drug is not based primarily on the coverage of prescription
7 drugs required by this section.
8 6. Prohibit the use of deductibles, coinsurance, copayments or
9 other cost sharing in relation to drug benefits and related medical
10 benefits offered.
11 P. For the purposes of subsection O of this section:
12 1. The acceptable standard medical reference compendia are the
13 following:
14 (a) The American hospital formulary service drug information, a
15 publication of the American society of health system pharmacists.
16 (b) The national comprehensive cancer network drugs and biologics
17 compendium.
18 (c) Thomson Micromedex compendium DrugDex.
19 (d) Elsevier gold standard's clinical pharmacology compendium.
20 (e) Other authoritative compendia as identified by the secretary of
21 the United States department of health and human services.
22 2. Medical literature may be accepted if all of the following
23 apply:
24 (a) At least two articles from major peer reviewed professional
25 medical journals have recognized, based on scientific or medical criteria,
26 the drug's safety and effectiveness for treatment of the indication for
27 which the drug has been prescribed.
28 (b) No article from a major peer reviewed professional medical
29 journal has concluded, based on scientific or medical criteria, that the
30 drug is unsafe or ineffective or that the drug's safety and effectiveness
31 cannot be determined for the treatment of the indication for which the
32 drug has been prescribed.
33 (c) The literature meets the uniform requirements for manuscripts
34 submitted to biomedical journals established by the international
35 committee of medical journal editors or is published in a journal
36 specified by the United States department of health and human services as
37 acceptable peer reviewed medical literature pursuant to section
38 186(t)(2)(B) of the social security act (42 United States Code section
39 1395x(t)(2)(B)).
40 Q. Any contract that is offered by a blanket disability insurer and
41 that contains a prescription drug benefit shall provide coverage of
42 medical foods to treat inherited metabolic disorders as provided by this
43 section.

1 R. The metabolic disorders triggering medical foods coverage under
2 this section shall:
3 1. Be part of the newborn screening program prescribed in section
4 36-694.
5 2. Involve amino acid, carbohydrate or fat metabolism.
6 3. Have medically standard methods of diagnosis, treatment and
7 monitoring including quantification of metabolites in blood, urine or
8 spinal fluid or enzyme or DNA confirmation in tissues.
9 4. Require specially processed or treated medical foods that are
10 generally available only under the supervision and direction of a
11 physician who is licensed pursuant to title 32, chapter 13 or 17 or a
12 registered nurse practitioner who is licensed pursuant to title 32,
13 chapter 15, that must be consumed throughout life and without which the
14 person may suffer serious mental or physical impairment.
15 S. Medical foods eligible for coverage under this section shall be
16 prescribed or ordered under the supervision of a physician licensed
17 pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner
18 who is licensed pursuant to title 32, chapter 15 as medically necessary
19 for the therapeutic treatment of an inherited metabolic disease.
20 T. An insurer shall cover at least fifty percent of the cost of
21 medical foods prescribed to treat inherited metabolic disorders and
22 covered pursuant to this section. An insurer may limit the maximum annual
23 benefit for medical foods under this section to $5,000, which applies to
24 the cost of all prescribed modified low protein foods and metabolic
25 formula.
26 U. Any blanket disability policy that provides coverage for:
27 1. Prescription drugs shall also provide coverage for any
28 prescribed drug or device that is approved by the United States food and
29 drug administration for use as a contraceptive. A blanket disability
30 insurer may use a drug formulary, multitiered drug formulary or list but
31 that formulary or list shall include oral, implant and injectable
32 contraceptive drugs, intrauterine devices and prescription barrier
33 methods. The blanket disability insurer may not impose deductibles,
34 coinsurance, copayments or other cost containment measures for
35 contraceptive drugs that are greater than the deductibles, coinsurance,
36 copayments or other cost containment measures for other drugs on the same
37 level of the formulary or list.
38 2. Outpatient health care services shall also provide coverage for
39 outpatient contraceptive services. For the purposes of this paragraph,
40 "outpatient contraceptive services" means consultations, examinations,
41 procedures and medical services provided on an outpatient basis and
42 related to the use of approved United States food and drug administration
43 prescription contraceptive methods to prevent unintended pregnancies.
44 V. Notwithstanding subsection U of this section, a religiously
45 affiliated employer may require that the insurer provide a blanket

1 disability policy without coverage for specific items or services required
2 under subsection U of this section because providing or paying for
3 coverage of the specific items or services is contrary to the religious
4 beliefs of the religiously affiliated employer offering the plan. If a
5 religiously affiliated employer objects to providing coverage for specific
6 items or services required under subsection U of this section, a written
7 affidavit shall be filed with the insurer stating the objection. On
8 receipt of the affidavit, the insurer shall issue to the religiously
9 affiliated employer a blanket disability policy that excludes coverage for
10 specific items or services required under subsection U of this section.
11 The insurer shall retain the affidavit for the duration of the blanket
12 disability policy and any renewals of the policy. This subsection shall
13 not exclude coverage for prescription contraceptive methods ordered by a
14 health care provider with prescriptive authority for medical indications
15 other than for contraceptive, abortifacient, abortion or sterilization
16 purposes. A religiously affiliated employer offering the policy may state
17 religious beliefs in its affidavit and may require the insured to first
18 pay for the prescription and then submit a claim to the insurer along with
19 evidence that the prescription is not for a purpose covered by the
20 objection. An insurer may charge an administrative fee for handling these
21 claims under this subsection.
22 W. Subsection V of this section does not authorize a religiously
23 affiliated employer to obtain an employee's protected health information
24 or to violate the health insurance portability and accountability act of
25 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
26 pursuant to that act.
27 X. Subsection V of this section shall not be construed to restrict
28 or limit any protections against employment discrimination that are
29 prescribed in federal or state law.
30 Y. For the purposes of:
31 1. This section:
32 (a) "Inherited metabolic disorder" means a disease caused by an
33 inherited abnormality of body chemistry and includes a disease tested
34 under the newborn screening program prescribed in section 36-694.
35 (b) "Medical foods" means modified low protein foods and metabolic
36 formula.
37 (c) "Metabolic formula" means foods that are all of the following:
38 (i) Formulated to be consumed or administered enterally under the
39 supervision of a physician who is licensed pursuant to title 32, chapter
40 13 or 17 or a registered nurse practitioner who is licensed pursuant to
41 title 32, chapter 15.
42 (ii) Processed or formulated to be deficient in one or more of the
43 nutrients present in typical foodstuffs.
44 (iii) Administered for the medical and nutritional management of a
45 person who has limited capacity to metabolize foodstuffs or certain

1 nutrients contained in the foodstuffs or who has other specific nutrient
2 requirements as established by medical evaluation.
3 (iv) Essential to a person's optimal growth, health and metabolic
4 homeostasis.
5 (d) "Modified low protein foods" means foods that are all of the
6 following:
7 (i) Formulated to be consumed or administered enterally under the
8 supervision of a physician who is licensed pursuant to title 32, chapter
9 13 or 17 or a registered nurse practitioner who is licensed pursuant to
10 title 32, chapter 15.
11 (ii) Processed or formulated to contain less than one gram of
12 protein per unit of serving, but does not include a natural food that is
13 naturally low in protein.
14 (iii) Administered for the medical and nutritional management of a
15 person who has limited capacity to metabolize foodstuffs or certain
16 nutrients contained in the foodstuffs or who has other specific nutrient
17 requirements as established by medical evaluation.
18 (iv) Essential to a person's optimal growth, health and metabolic
19 homeostasis.
20 2. Subsection E of this section, ~~the term~~ "child", for purposes of
21 initial coverage of an adopted child or a child placed for adoption but
22 not for purposes of termination of coverage of such child, means a person
23 who is under eighteen years of age.
24 3. Subsections V and W of this section, "religiously affiliated
25 employer" means either:
26 (a) An entity for which all of the following apply:
27 (i) The entity primarily employs persons who share the religious
28 tenets of the entity.
29 (ii) The entity serves primarily persons who share the religious
30 tenets of the entity.
31 (iii) The entity is a nonprofit organization as described in
32 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as
33 amended.
34 (b) An entity whose articles of incorporation clearly state that it
35 is a religiously motivated organization and whose religious beliefs are
36 central to the organization's operating principles.
37 Sec. 6. Section 20-2325, Arizona Revised Statutes, is amended to
38 read:
39 20-2325. Diabetes; equipment; supplies
40 A. Any health benefits plan that is offered by an accountable
41 health plan and that provides coverage for diabetes shall also provide
42 coverage for equipment and supplies that are medically necessary and that
43 are prescribed by a health care provider, including:
44 1. Blood glucose monitors.
45 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.

B. ~~Nothing in~~ Subsection A of this section DOES NOT:

1. ~~Entitles~~ ENTITLE a member or enrollee of an accountable health plan to equipment or supplies for the treatment of diabetes that are not medically necessary as determined by the accountable health plan's medical director or the medical director's designee.

2. ~~Provides~~ PROVIDE coverage for diabetic supplies obtained by a member or enrollee of an accountable health plan without a prescription unless otherwise permitted pursuant to the terms of the health benefits plan.

3. ~~Prohibits~~ PROHIBIT an accountable health plan from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes, EXCEPT THAT AN ACCOUNTABLE HEALTH PLAN SHALL LIMIT THE TOTAL AMOUNT THAT A MEMBER OR ENROLLEE MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN $35 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE MEMBER'S OR ENROLLEE'S PRESCRIPTION. FOR THE PURPOSES OF THIS PARAGRAPH, "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO A SUBSCRIBER TO TREAT THE MEMBER'S OR ENROLLEE'S CONDITION, THAT CONTAINS INSULIN AND THAT IS USED TO TREAT DIABETES.