

State of Arizona
House of Representatives
Fiftieth Legislature
Second Regular Session
2012

HOUSE BILL 2625

AN ACT

AMENDING SECTIONS 20-826, 20-1057.08, 20-1402, 20-1404 AND 20-2329, ARIZONA
REVISED STATUTES; RELATING TO HEALTH 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 be
6 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 of
11 services with which the corporation has contracted for hospital, medical,
12 dental or optometric services.

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

16 1. Performance of any surgical service that is covered by the terms of
17 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 would
21 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 would
24 have been covered.

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

28 D. Each contract for dental or optometric services shall be so written
29 that the corporation shall pay benefits for contracted dental or optometric
30 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 payable
34 with respect to a newly born child of the insured from the instant of such
35 child's birth, to a child adopted by the insured, regardless of the age at
36 which the child was adopted, and to a child who has been placed for adoption
37 with the insured and for whom the application and approval procedures for
38 adoption pursuant to section 8-105 or 8-108 have been completed to the same
39 extent that such coverage applies to other members of the family. The
40 coverage for newly born or adopted children or children placed for adoption
41 shall include coverage of injury or sickness, including necessary care and
42 treatment of medically diagnosed congenital defects and birth abnormalities.
43 If payment of a specific premium is required to provide coverage for a child,
44 the contract may require that notification of birth, adoption or adoption
45 placement of the child and payment of the required premium must be furnished

1 to the insurer within thirty-one days after the date of birth, adoption or
2 adoption placement in order to have the coverage continue beyond the
3 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 dependent
6 child shall terminate on attainment of the limiting age for dependent
7 children specified in the contract shall also provide in substance that
8 attainment of such limiting age shall not operate to terminate the coverage
9 of such child while the child is and continues to be both incapable of
10 self-sustaining employment by reason of intellectual disability or physical
11 handicap and chiefly dependent on the subscriber for support and maintenance.
12 Proof of such incapacity and dependency shall be furnished to the corporation
13 by the subscriber within thirty-one days of the child's attainment of the
14 limiting age and subsequently as may be required by the corporation, but not
15 more frequently than annually after the two-year period following the child's
16 attainment of the limiting age.

17 G. No corporation may cancel or refuse to renew any subscriber's
18 contract without giving notice of such cancellation or nonrenewal to the
19 subscriber under such contract. A notice by the corporation to the
20 subscriber of cancellation or nonrenewal of a subscription contract shall be
21 mailed to the named subscriber at least forty-five days before the effective
22 date of such cancellation or nonrenewal. The notice shall include or be
23 accompanied by a statement in writing of the reasons for such action by the
24 corporation. Failure of the corporation to comply with this subsection shall
25 invalidate any cancellation or nonrenewal except a cancellation or nonrenewal
26 for nonpayment of premium.

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

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

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

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

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

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

- 5 1. The child is adopted within one year of birth.
- 6 2. The insured is legally obligated to pay the costs of birth.
- 7 3. All preexisting conditions and other limitations have been met by
8 the insured.
- 9 4. The insured has notified the insurer of the insured's acceptability
10 to adopt children pursuant to section 8-105, within sixty days after such
11 approval or within sixty days after a change in insurance policies, plans or
12 companies.

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

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

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

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

42 N. Any contract that provides maternity benefits shall not restrict
43 benefits for any hospital length of stay in connection with childbirth for
44 the mother or the newborn child to less than forty-eight hours following a
45 normal vaginal delivery or ninety-six hours following a cesarean section.

1 The contract shall not require the provider to obtain authorization from the
2 corporation for prescribing the minimum length of stay required by this
3 subsection. The contract may provide that an attending provider in
4 consultation with the mother may discharge the mother or the newborn child
5 before the expiration of the minimum length of stay required by this
6 subsection. The corporation shall not:

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

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

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

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

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

23 O. Nothing in subsection N of this section:

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

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

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

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

39 1. Blood glucose monitors.

40 2. Blood glucose monitors for the legally blind.

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

43 4. Insulin preparations and glucagon.

44 5. Insulin cartridges.

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

1 7. Injection aids.

2 8. Insulin cartridges for the legally blind.

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

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

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

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

12 Q. Nothing in subsection P of this section prohibits a medical service
13 corporation, a hospital service corporation or a hospital, medical, dental
14 and optometric service corporation from imposing deductibles, coinsurance or
15 other cost sharing in relation to benefits for equipment or supplies for the
16 treatment of diabetes.

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

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

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

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

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

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

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

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

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

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

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

11 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 X. A hospital service corporation or medical service corporation shall
35 cover at least fifty per cent of the cost of medical foods prescribed to
36 treat inherited metabolic disorders and covered pursuant to this section. A
37 hospital service corporation or medical service corporation may limit the
38 maximum annual benefit for medical foods under this section to five thousand
39 dollars, which applies to the cost of all prescribed modified low protein
40 foods and metabolic formula.

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

43 1. If the contract provides coverage for prescription drugs, the
44 contract shall provide coverage for any prescribed drug or device that is
45 approved by the United States food and drug administration for use as a

1 contraceptive. A corporation may use a drug formulary, multitiered drug
2 formulary or list but that formulary or list shall include oral, implant and
3 injectable contraceptive drugs, intrauterine devices and prescription barrier
4 methods if the corporation does not impose deductibles, coinsurance,
5 copayments or other cost containment measures for contraceptive drugs that
6 are greater than the deductibles, coinsurance, copayments or other cost
7 containment measures for other drugs on the same level of the formulary or
8 list.

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

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

18 ~~Z. Notwithstanding subsection Y of this section, a religious employer
19 whose religious tenets prohibit the use of prescribed contraceptive methods
20 may require that the corporation provide a contract without coverage for all
21 United States food and drug administration approved contraceptive methods. A
22 religious employer shall submit a written affidavit to the corporation
23 stating that it is a religious employer. On receipt of the affidavit, the
24 corporation shall issue to the religious employer a contract that excludes
25 coverage of prescription contraceptive methods. The corporation shall retain
26 the affidavit for the duration of the contract and any renewals of the
27 contract. Before enrollment in the plan, every religious employer that
28 invokes this exemption shall provide prospective subscribers written notice
29 that the religious employer refuses to cover all United States food and drug
30 administration approved contraceptive methods for religious reasons. This
31 subsection shall not exclude coverage for prescription contraceptive methods
32 ordered by a health care provider with prescriptive authority for medical
33 indications other than to prevent an unintended pregnancy. A corporation may
34 require the subscriber to first pay for the prescription and then submit a
35 claim to the corporation along with evidence that the prescription is for a
36 noncontraceptive purpose. A corporation may charge an administrative fee for
37 handling these claims. A religious employer shall not discriminate against
38 an employee who independently chooses to obtain insurance coverage or
39 prescriptions for contraceptives from another source.~~

40 Z. NOTWITHSTANDING SUBSECTION Y OF THIS SECTION, A CONTRACT DOES NOT
41 FAIL TO MEET THE REQUIREMENTS OF SUBSECTION Y OF THIS SECTION IF THE
42 CONTRACT'S FAILURE TO PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED
43 UNDER SUBSECTION Y OF THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR
44 COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS
45 BELIEFS OF THE EMPLOYER, SPONSOR, ISSUER, CORPORATION OR OTHER ENTITY

1 OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS
2 BELIEFS OF THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN OBJECTION
3 TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE
4 CORPORATION STATING THE OBJECTION. THE CORPORATION SHALL RETAIN THE
5 AFFIDAVIT FOR THE DURATION OF THE CONTRACT AND ANY RENEWALS OF THE
6 CONTRACT. THIS SUBSECTION SHALL NOT EXCLUDE COVERAGE FOR PRESCRIPTION
7 CONTRACEPTIVE METHODS ORDERED BY A HEALTH CARE PROVIDER WITH PRESCRIPTIVE
8 AUTHORITY FOR MEDICAL INDICATIONS OTHER THAN FOR CONTRACEPTIVE,
9 ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. A CORPORATION, EMPLOYER,
10 SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE PLAN MAY STATE RELIGIOUS BELIEFS
11 OR MORAL CONVICTIONS IN ITS AFFIDAVIT THAT REQUIRE THE SUBSCRIBER TO FIRST
12 PAY FOR THE PRESCRIPTION AND THEN SUBMIT A CLAIM TO THE CORPORATION ALONG
13 WITH EVIDENCE THAT THE PRESCRIPTION IS NOT IN WHOLE OR IN PART FOR A PURPOSE
14 COVERED BY THE OBJECTION. A CORPORATION MAY CHARGE AN ADMINISTRATIVE FEE FOR
15 HANDLING THESE CLAIMS.

16 AA. For the purposes of:

17 1. This section:

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

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

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

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

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

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

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

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

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

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

43 (iii) Administered for the medical and nutritional management of a
44 person who has limited capacity to metabolize foodstuffs or certain nutrients

1 contained in the foodstuffs or who has other specific nutrient requirements
2 as established by medical evaluation.

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

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

9 ~~3. Subsection Z of this section, "religious employer" means an entity
10 for which all of the following apply:~~

11 ~~(a) The entity primarily employs persons who share the religious
12 tenets of the entity.~~

13 ~~(b) The entity primarily serves persons who share the religious tenets
14 of the entity.~~

15 ~~(c) The entity is a nonprofit organization as described in section
16 6033(a)(2)(A) (i) or (iii) of the internal revenue code of 1986, as amended.~~

17 Sec. 2. Section 20-1057.08, Arizona Revised Statutes, is amended to
18 read:

19 20-1057.08. Prescription contraceptive drugs and devices

20 A. If a health care services organization issues evidence of coverage
21 that provides coverage for:

22 1. Prescription drugs, the evidence of coverage shall provide coverage
23 for any prescribed drug or device that is approved by the United States food
24 and drug administration for use as a contraceptive. A health care services
25 organization may use a drug formulary, multitiered drug formulary or list but
26 that formulary or list shall include oral, implant and injectable
27 contraceptive drugs, intrauterine devices and prescription barrier methods if
28 the health care services organization does not impose deductibles,
29 coinsurance, copayments or other cost containment measures for contraceptive
30 drugs that are greater than the deductibles, coinsurance, copayments or other
31 cost containment measures for other drugs on the same level of the formulary
32 or list.

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

39 B. Notwithstanding subsection A **OF THIS SECTION**, ~~a religious employer
40 whose religious tenets prohibit the use of prescribed contraceptive methods
41 may require that the health care services organization provide coverage that
42 excludes all federal food and drug administration approved contraceptive
43 methods. A religious employer shall submit a written affidavit to the health
44 care services organization stating that it is a religious employer. On
45 receipt of the affidavit, the health care services organization shall provide~~

1 ~~coverage to the religious employer that excludes prescription contraceptive~~
2 ~~methods.~~ AN EVIDENCE OF COVERAGE DOES NOT FAIL TO MEET THE REQUIREMENTS OF
3 SUBSECTION A OF THIS SECTION IF THE EVIDENCE OF COVERAGE'S FAILURE TO PROVIDE
4 COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION A OF THIS
5 SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR
6 SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, SPONSOR,
7 ISSUER, HEALTH CARE SERVICES ORGANIZATION OR OTHER ENTITY OFFERING THE PLAN
8 OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE
9 PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS
10 SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE HEALTH CARE SERVICES
11 ORGANIZATION STATING THE OBJECTION. The health care services organization
12 shall retain the affidavit for the duration of the coverage and any renewals
13 of the coverage.

14 ~~C. Before enrollment in the health care plan, every religious employer~~
15 ~~that invokes this exemption shall provide prospective enrollees written~~
16 ~~notice that the religious employer refuses to cover all federal food and drug~~
17 ~~administration approved contraceptive methods for religious reasons.~~

18 ~~D.~~ C. Subsection B OF THIS SECTION does not exclude coverage for
19 prescription contraceptive methods ordered by a health care provider with
20 prescriptive authority for medical indications other than ~~to prevent an~~
21 ~~unintended pregnancy.~~ A health care services organization may require FOR
22 CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. A HEALTH
23 CARE SERVICES ORGANIZATION, EMPLOYER, SPONSOR, ISSUER OR OTHER ENTITY
24 OFFERING THE PLAN MAY STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT THAT REQUIRE
25 the enrollee to first pay for the prescription and then submit a claim to the
26 health care services organization along with evidence that the prescription
27 is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART FOR A PURPOSE
28 COVERED BY THE OBJECTION. A health care services organization may charge an
29 administrative fee for handling claims under this subsection.

30 ~~E. A religious employer shall not discriminate against an employee who~~
31 ~~independently chooses to obtain insurance coverage or prescriptions for~~
32 ~~contraceptives from another source.~~

33 ~~F.~~ D. This section does not apply to evidences of coverage issued to
34 individuals on a nongroup basis.

35 ~~G. For the purposes of this section, "religious employer" means an~~
36 ~~entity for which all of the following apply:~~

37 ~~1. The entity primarily employs persons who share the religious tenets~~
38 ~~of the entity.~~

39 ~~2. The entity serves primarily persons who share the religious tenets~~
40 ~~of the entity.~~

41 ~~3. The entity is a nonprofit organization as described in section~~
42 ~~6033(a)(2)(A)i or iii of the internal revenue code of 1986, as amended.~~

1 Sec. 3. Section 20-1402, Arizona Revised Statutes, is amended to read:
2 20-1402. Provisions of group disability policies; definitions

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

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

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

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

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

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

43 (b) For any home health services that are performed by a licensed home
44 health agency and that a physician has prescribed in lieu of hospital

1 services, as defined by the director, providing the hospital services would
2 have been covered.

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

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

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

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

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

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

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

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

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

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

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

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

41 8. The coverage prescribed by paragraph 7 of this subsection is excess
42 to any other coverage the natural mother may have for maternity benefits
43 except coverage made available to persons pursuant to title 36, chapter 29,
44 but not including coverage made available to persons defined as eligible
45 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If

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

8 B. Any policy 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 policy shall not require the provider to obtain authorization from the
13 insurer for prescribing the minimum length of stay required by this
14 subsection. The policy may provide that an attending provider in
15 consultation with the mother may discharge the mother or the newborn child
16 before the expiration of the minimum length of stay required by this
17 subsection. The insurer shall not:

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

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

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

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

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

34 C. Nothing in subsection B of this section:

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

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

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

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

- 7 1. Blood glucose monitors.
- 8 2. Blood glucose monitors for the legally blind.
- 9 3. Test strips for glucose monitors and visual reading and urine
10 testing strips.
- 11 4. Insulin preparations and glucagon.
- 12 5. Insulin cartridges.
- 13 6. Drawing up devices and monitors for the visually impaired.
- 14 7. Injection aids.
- 15 8. Insulin cartridges for the legally blind.
- 16 9. Syringes and lancets including automatic lancing devices.
- 17 10. Prescribed oral agents for controlling blood sugar that are
18 included on the plan formulary.

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

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

25 E. Nothing in subsection D of this section prohibits a group
26 disability insurer from imposing deductibles, coinsurance or other cost
27 sharing in relation to benefits for equipment or supplies for the treatment
28 of diabetes.

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

- 41 1. Require coverage of any prescription drug used in the treatment of
42 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 not
2 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 of
5 prescription drugs that have not been approved by the United States food and
6 drug administration.

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

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

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

17 G. For the purposes of subsection F 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 apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 M. Notwithstanding subsection L of this section, ~~a religious employer~~
2 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~
3 ~~may require that the insurer provide a group disability policy without~~
4 ~~coverage for all United States food and drug administration approved~~
5 ~~contraceptive methods. A religious employer shall submit a written affidavit~~
6 ~~to the insurer stating that it is a religious employer. On receipt of the~~
7 ~~affidavit, the insurer shall issue to the religious employer a group~~
8 ~~disability policy that excludes coverage of prescription contraceptive~~
9 ~~methods.~~ A GROUP DISABILITY POLICY DOES NOT FAIL TO MEET THE REQUIREMENTS OF
10 SUBSECTION L OF THIS SECTION IF THE POLICY'S FAILURE TO PROVIDE COVERAGE OF
11 SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION L OF THIS SECTION IS
12 BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS
13 CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, SPONSOR, ISSUER, INSURER
14 OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO
15 THE RELIGIOUS BELIEFS OF THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN
16 OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH
17 THE INSURER STATING THE OBJECTION. The insurer shall retain the affidavit
18 for the duration of the group disability policy and any renewals of the
19 policy. ~~Before a policy is issued, every religious employer that invokes~~
20 ~~this exemption shall provide prospective insureds written notice that the~~
21 ~~religious employer refuses to cover all United States food and drug~~
22 ~~administration approved contraceptive methods for religious reasons.~~ This
23 subsection shall not exclude coverage for prescription contraceptive methods
24 ordered by a health care provider with prescriptive authority for medical
25 indications other than ~~to prevent an unintended pregnancy~~ FOR CONTRACEPTIVE,
26 ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. An insurer, EMPLOYER,
27 SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE POLICY may STATE RELIGIOUS
28 BELIEFS IN ITS AFFIDAVIT THAT require the insured to first pay for the
29 prescription and then submit a claim to the insurer along with evidence that
30 the prescription is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART
31 FOR A PURPOSE COVERED BY THE OBJECTION. An insurer may charge an
32 administrative fee for handling these claims. ~~A religious employer shall not~~
33 ~~discriminate against an employee who independently chooses to obtain~~
34 ~~insurance coverage or prescriptions for contraceptives from another source.~~

35 N. For the purposes of:

36 1. This section:

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

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

42 (c) "Metabolic formula" means foods that are all of the 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 13

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

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

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

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

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

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

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

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

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

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

30 ~~3. Subsection M of this section, "religious employer" means an entity
31 for which all of the following apply:~~

32 ~~(a) The entity primarily employs persons who share the religious
33 tenets of the entity.~~

34 ~~(b) The entity serves primarily persons who share the religious tenets
35 of the entity.~~

36 ~~(c) The entity is a nonprofit organization as described in section
37 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.~~

38 Sec. 4. Section 20-1404, Arizona Revised Statutes, is amended to read:
39 20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

15 6. Under a policy or contract issued to a sports team or to a camp or
16 sponsor thereof, which team or camp or sponsor thereof shall be deemed the
17 policyholder, covering members or campers.

18 7. Under a policy or contract that is issued to any other
19 substantially similar group and that, in the discretion of the director, may
20 be subject to the issuance of a blanket disability policy or contract.

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

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

36 D. Nothing contained in this section shall be deemed to affect the
37 legal liability of policyholders for the death of or injury to any member of
38 the group.

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

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

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

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

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

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

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

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

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

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

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

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

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

5 1. The child is adopted within one year of birth.
6 2. The insured is legally obligated to pay the costs of birth.
7 3. All preexisting conditions and other limitations have been met by
8 the insured.

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

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

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

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

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

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

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

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

5 L. Nothing in subsection K of this section:

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

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

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

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

21 1. Blood glucose monitors.

22 2. Blood glucose monitors for the legally blind.

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

25 4. Insulin preparations and glucagon.

26 5. Insulin cartridges.

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

28 7. Injection aids.

29 8. Insulin cartridges for the legally blind.

30 9. Syringes and lancets including automatic lancing devices.

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

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

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

39 N. Nothing in subsection M of this section prohibits a blanket
40 disability insurer from imposing deductibles, coinsurance or other cost
41 sharing in relation to benefits for equipment or supplies for the treatment
42 of diabetes.

43 O. Any contract that provides coverage for prescription drugs shall
44 not limit or exclude coverage for any prescription drug prescribed for the
45 treatment of cancer on the basis that the prescription drug has not been

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

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

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

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

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

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

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

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

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

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

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

37 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

34 T. An insurer shall cover at least fifty per cent of the cost of
35 medical foods prescribed to treat inherited metabolic disorders and covered
36 pursuant to this section. An insurer may limit the maximum annual benefit
37 for medical foods under this section to five thousand dollars which applies
38 to the cost of all prescribed modified low protein foods and metabolic
39 formula.

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

41 1. Prescription drugs shall also provide coverage for any prescribed
42 drug or device that is approved by the United States food and drug
43 administration for use as a contraceptive. A blanket disability insurer may
44 use a drug formulary, multitiered drug formulary or list but that formulary
45 or list shall include oral, implant and injectable contraceptive drugs,

1 intrauterine devices and prescription barrier methods if the blanket
2 disability insurer does not impose deductibles, coinsurance, copayments or
3 other cost containment measures for contraceptive drugs that are greater than
4 the deductibles, coinsurance, copayments or other cost containment measures
5 for other drugs on the same level of the formulary or list.

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

12 V. Notwithstanding subsection U of this section, ~~a religious employer~~
13 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~
14 ~~may require that the insurer provide a blanket disability policy without~~
15 ~~coverage for all United States food and drug administration approved~~
16 ~~contraceptive methods. A religious employer shall submit a written affidavit~~
17 ~~to the insurer stating that it is a religious employer. On receipt of the~~
18 ~~affidavit, the insurer shall issue to the religious employer a blanket~~
19 ~~disability policy that excludes coverage of prescription contraceptive~~
20 ~~methods.~~ A BLANKET DISABILITY POLICY DOES NOT FAIL TO MEET THE REQUIREMENTS
21 OF SUBSECTION U OF THIS SECTION IF THE POLICY'S FAILURE TO PROVIDE COVERAGE
22 OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION U OF THIS SECTION IS
23 BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS
24 CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, SPONSOR, ISSUER, INSURER
25 OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO
26 THE RELIGIOUS BELIEFS OF THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN
27 OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH
28 THE INSURER STATING THE OBJECTION. The insurer shall retain the affidavit
29 for the duration of the blanket disability policy and any renewals of the
30 policy. ~~Before a policy is issued, every religious employer that invokes~~
31 ~~this exemption shall provide prospective insureds written notice that the~~
32 ~~religious employer refuses to cover all United States food and drug~~
33 ~~administration approved contraceptive methods for religious reasons.~~ This
34 subsection shall not exclude coverage for prescription contraceptive methods
35 ordered by a health care provider with prescriptive authority for medical
36 indications other than ~~to prevent an unintended pregnancy~~ FOR CONTRACEPTIVE,
37 ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. An insurer, EMPLOYER,
38 SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE POLICY may STATE RELIGIOUS
39 BELIEFS IN ITS AFFIDAVIT THAT require the insured to first pay for the
40 prescription and then submit a claim to the insurer along with evidence that
41 the prescription is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART
42 FOR A PURPOSE COVERED BY THE OBJECTION. An insurer may charge an
43 administrative fee for handling these claims under this subsection. ~~A~~
44 ~~religious employer shall not discriminate against an employee who~~

~~1 independently chooses to obtain insurance coverage or prescriptions for
2 contraceptives from another source.~~

3 W. 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 under
7 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 title
14 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 nutrients
19 contained in the foodstuffs or who has other specific nutrient requirements
20 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 13
27 or 17 or a registered nurse practitioner who is licensed pursuant to title
28 32, chapter 15.

29 (ii) Processed or formulated to contain less than one gram of protein
30 per unit of serving, but does not include a natural food that is naturally
31 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 nutrients
34 contained in the foodstuffs or who has other specific nutrient requirements
35 as established by medical evaluation.

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

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

~~42 3. Subsection V of this section, "religious employer" means an entity
43 for which all of the following apply:~~

~~44 (a) The entity primarily employs persons who share the religious
45 tenets of the entity.~~

1 ~~(b) The entity serves primarily persons who share the religious tenets~~
2 ~~of the entity.~~

3 ~~(c) The entity is a nonprofit organization as described in section~~
4 ~~6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.~~

5 Sec. 5. Section 20-2329, Arizona Revised Statutes, is amended to read:
6 20-2329. Prescription contraceptive drugs and devices

7 A. An accountable health plan that provides a health benefits plan
8 that provides coverage for:

9 1. Prescription drugs shall also provide coverage for any prescribed
10 drug or device that is approved by the United States food and drug
11 administration for use as a contraceptive. An accountable health plan may
12 use a drug formulary, multitiered drug formulary or list but that formulary
13 or list shall include oral, implant and injectable contraceptive drugs,
14 intrauterine devices and prescription barrier methods if the accountable
15 health plan does not impose deductibles, coinsurance, copayments or other
16 cost containment measures for contraceptive drugs that are greater than the
17 deductibles, coinsurance, copayments or other cost containment measures for
18 other drugs on the same level of the formulary or list.

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

25 B. Notwithstanding subsection A **OF THIS SECTION**, ~~a religious employer~~
26 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~
27 ~~may require that the accountable health plan provide a health benefits plan~~
28 ~~without coverage for all federal food and drug administration approved~~
29 ~~contraceptive methods. A religious employer shall submit a written affidavit~~
30 ~~to the accountable health plan stating that it is a religious employer. On~~
31 ~~receipt of the affidavit, the accountable health plan shall issue to the~~
32 ~~religious employer a health benefits plan that excludes coverage of~~
33 ~~prescription contraceptive methods.~~ **AN ACCOUNTABLE HEALTH PLAN DOES NOT FAIL**
34 **TO MEET THE REQUIREMENTS OF SUBSECTION A OF THIS SECTION IF THE PLAN'S**
35 **FAILURE TO PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER**
36 **SUBSECTION A OF THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF**
37 **THE SPECIFIC ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE**
38 **EMPLOYER, SPONSOR, ISSUER, ACCOUNTABLE HEALTH PLAN OR OTHER ENTITY OFFERING**
39 **THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF**
40 **THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS**
41 **SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE ACCOUNTABLE HEALTH**
42 **PLAN STATING THE OBJECTION.** The accountable health plan shall retain the
43 affidavit for the duration of the health benefits plan and any renewals of
44 the plan.

1 ~~C. Before enrollment in the plan, every religious employer that~~
2 ~~invokes this exemption shall provide prospective enrollees written notice~~
3 ~~that the religious employer refuses to cover all federal food and drug~~
4 ~~administration approved contraceptive methods for religious reasons.~~

5 ~~D.~~ C. Subsection B OF THIS SECTION shall not exclude coverage for
6 prescription contraceptive methods ordered by a health care provider with
7 prescriptive authority for medical indications other than ~~to prevent an~~
8 ~~unintended pregnancy~~ FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR
9 STERILIZATION PURPOSES. An accountable health plan, EMPLOYER, SPONSOR,
10 ISSUER OR OTHER ENTITY OFFERING THE PLAN may STATE RELIGIOUS BELIEFS IN ITS
11 AFFIDAVIT THAT require the enrollee to first pay for the prescription and
12 then submit a claim to the accountable health plan along with evidence that
13 the prescription is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART
14 FOR A PURPOSE COVERED BY THE OBJECTION. An accountable health plan may charge
15 an administrative fee for handling claims under this subsection.

16 ~~E. A religious employer shall not discriminate against an employee who~~
17 ~~independently chooses to obtain insurance coverage or prescriptions for~~
18 ~~contraceptives from another source.~~

19 ~~F. For the purposes of this section, "religious employer" means an~~
20 ~~entity for which all of the following apply:~~

21 ~~1. The entity primarily employs persons who share the religious tenets~~
22 ~~of the entity.~~

23 ~~2. The entity serves primarily persons who share the religious tenets~~
24 ~~of the entity.~~

25 ~~3. The entity is a nonprofit organization as described in section~~
26 ~~6033(a)(2)(A)i or iii of the internal revenue code of 1986, as amended.~~