

REFERENCE TITLE: insurance; cancer screening examinations

State of Arizona  
House of Representatives  
Forty-eighth Legislature  
First Regular Session  
2007

## HB 2086

Introduced by  
Representatives Schapira, Ableser, Farley, Gallardo, Pancrazi, Saradnik,  
Sinema: Alvarez, Cajero Bedford, Campbell CH, Campbell CL, DeSimone,  
Garcia M, Lopes, Lopez, Lujan, McGuire, Meza, Prezelski, Rios P, Thrasher,  
Tom

### AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1402, 20-1404, 20-2318 AND 20-2341, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-826.04; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.11; AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1342.06; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-1402.03 AND 20-1404.03; RELATING TO 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 ~~shall~~, as to such coverage of family  
33 members, SHALL also provide that the benefits applicable for children shall  
34 be 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 the  
36 age at which the child was adopted, and to a child who has been placed for  
37 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 of  
40 the family. The coverage for newly born or adopted children or children  
41 placed for adoption shall include coverage of injury or sickness, including  
42 necessary care and treatment of medically diagnosed congenital defects and  
43 birth abnormalities. If payment of a specific premium is required to provide  
44 coverage for a child, the contract may require that notification of birth,  
45 adoption or adoption placement of the child and payment of the required

1 premium must be furnished to the insurer within thirty-one days after the  
2 date of birth, adoption or adoption placement in order to have the coverage  
3 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 dependent  
6 child shall terminate ~~upon~~ 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 mental retardation or physical  
11 handicap and chiefly dependent ~~upon~~ ON the subscriber for support and  
12 maintenance. Proof of such incapacity and dependency shall be furnished to  
13 the corporation by the subscriber within thirty-one days of the child's  
14 attainment of the limiting age and subsequently as may be required by the  
15 corporation, but not more frequently than annually after the two-year period  
16 following the child's 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 ~~the provisions of~~  
25 this subsection shall invalidate any cancellation or nonrenewal except a  
26 cancellation or nonrenewal 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.~~ 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 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.~~ J. The coverage prescribed by subsection ~~J.~~ I of this section is  
14 excess to any other coverage the natural mother may have for maternity  
15 benefits except coverage made available to persons pursuant to title 36,  
16 chapter 29 but not including coverage made available to persons defined as  
17 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)  
18 and (e). If such other coverage exists, the agency, attorney or individual  
19 arranging the adoption shall make arrangements for the insurance to pay those  
20 costs that may be covered under that policy and shall advise the adopting  
21 parent in writing of the existence and extent of the coverage without  
22 disclosing any confidential information such as the identity of the natural  
23 parent. The insured adopting parents shall notify their insurer of the  
24 existence and extent of the other coverage.

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

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

- 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.

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

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

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

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

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

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

27           ~~Q~~. N. Nothing in subsection ~~N~~ M of this section:

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

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

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

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

43           1. Blood glucose monitors.

44           2. Blood glucose monitors for the legally blind.

- 1           3. Test strips for glucose monitors and visual reading and urine  
2 testing strips.
- 3           4. Insulin preparations and glucagon.
- 4           5. Insulin cartridges.
- 5           6. Drawing up devices and monitors for the visually impaired.
- 6           7. Injection aids.
- 7           8. Insulin cartridges for the legally blind.
- 8           9. Syringes and lancets, including automatic lancing devices.
- 9           10. Prescribed oral agents for controlling blood sugar that are  
10 included on the plan formulary.
- 11          11. To the extent coverage is required under medicare, podiatric  
12 appliances for prevention of complications associated with diabetes.
- 13          12. Any other device, medication, equipment or supply for which  
14 coverage is required under medicare from and after January 1, 1999. The  
15 coverage required in this paragraph is effective six months after the  
16 coverage is required under medicare.
- 17          ~~Q.~~ P. Nothing in subsection ~~P-0~~ of this section prohibits a medical  
18 service corporation, a hospital service corporation or a hospital, medical,  
19 dental and optometric service corporation from imposing deductibles,  
20 coinsurance or other cost sharing in relation to benefits for equipment or  
21 supplies for the treatment of diabetes.
- 22          ~~R.~~ Q. Any hospital or medical service contract that provides coverage  
23 for prescription drugs shall not limit or exclude coverage for any  
24 prescription drug prescribed for the treatment of cancer on the basis that  
25 the prescription drug has not been approved by the United States food and  
26 drug administration for the treatment of the specific type of cancer for  
27 which the prescription drug has been prescribed, if the prescription drug has  
28 been recognized as safe and effective for treatment of that specific type of  
29 cancer in one or more of the standard medical reference compendia prescribed  
30 in subsection ~~S- R~~ of this section or medical literature that meets the  
31 criteria prescribed in subsection ~~S- R~~ of this section. The coverage  
32 required under this subsection includes covered medically necessary services  
33 associated with the administration of the prescription drug. This subsection  
34 does not:
  - 35           1. Require coverage of any prescription drug used in the treatment of  
36 a type of cancer if the United States food and drug administration has  
37 determined that the prescription drug is contraindicated for that type of  
38 cancer.
  - 39           2. Require coverage for any experimental prescription drug that is not  
40 approved for any indication by the United States food and drug  
41 administration.
  - 42           3. Alter any law with regard to provisions that limit the coverage of  
43 prescription drugs that have not been approved by the United States food and  
44 drug administration.

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

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

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

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

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

14           (a) The American medical association drug evaluations, a publication  
15 of the American medical association.

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

18           (c) Drug information for the health care provider, a publication of  
19 the United States pharmacopoeia convention.

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

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

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

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

36           ~~T.~~ S. A corporation shall not issue or deliver any advertising matter  
37 or sales material to any person in this state until the corporation files the  
38 advertising matter or sales material with the director. This subsection does  
39 not require a corporation to have the prior approval of the director to issue  
40 or deliver the advertising matter or sales material. If the director finds  
41 that the advertising matter or sales material, in whole or in part, is false,  
42 deceptive or misleading, the director may issue an order disapproving the  
43 advertising matter or sales material, directing the corporation to cease and  
44 desist from issuing, circulating, displaying or using the advertising matter  
45 or sales material within a period of time specified by the director but not

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

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

21 ~~V.~~ U. The metabolic disorders triggering medical foods coverage under  
 22 this section shall:

23 1. Be part of the newborn screening program prescribed in section  
 24 36-694.

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

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

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

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

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



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

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

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

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

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

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

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

4 Sec. 2. Title 20, chapter 4, article 3, Arizona Revised Statutes, is  
5 amended by adding section 20-826.04, to read:

6 20-826.04. Subscription contracts: cancer screening  
7 examinations; coverage

8 ANY CONTRACT THAT IS OFFERED BY A HOSPITAL SERVICE CORPORATION OR  
9 MEDICAL SERVICE CORPORATION SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER  
10 SCREENING EXAMINATIONS ON REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL  
11 THE TERMS AND CONDITIONS OF THE CONTRACT AND ACCORDING TO THE FOLLOWING  
12 GUIDELINES:

13 1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST  
14 FIFTY YEARS OF AGE:

15 (a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.

16 (b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.

17 (c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.

18 (d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY  
19 TEN YEARS.

20 2. MAMMOGRAPHY SCREENING:

21 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS  
22 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.

23 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF  
24 AGE.

25 3. BREAST CANCER SCREENING:

26 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH  
27 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE  
28 BUT WHO IS UNDER FORTY YEARS OF AGE.

29 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST  
30 FORTY YEARS OF AGE.

31 4. CERVICAL CANCER SCREENING:

32 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS  
33 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A  
34 LIQUID-BASED PAP TEST.

35 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD  
36 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILLOMAVIRUS TEST AND A  
37 PAP TEST OR LIQUID-BASED PAP TEST.

38 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILLOMAVIRUS.

39 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT  
40 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL  
41 BIOPSY.

42 6. PROSTATE CANCER SCREENING:

43 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY  
44 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.

1 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT  
2 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST  
3 AND A DIGITAL RECTAL EXAMINATION.

4 Sec. 3. Section 20-1057, Arizona Revised Statutes, is amended to read:  
5 20-1057. Evidence of coverage by health care services  
6 organizations; renewability; definitions

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

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

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

33 D. No evidence of coverage or amendment to the coverage shall be  
34 issued or delivered to any person in this state until a copy of the form of  
35 the evidence of coverage or amendment to the coverage has been filed with and  
36 approved by the director.

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

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

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

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

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

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

6           G. The director shall approve any form of evidence of coverage if the  
7 requirements of subsections E and F of this section are met. It is unlawful  
8 to issue such form until approved. If the director does not disapprove any  
9 such form within forty-five days after the filing of the form, it is deemed  
10 approved. If the director disapproves a form of evidence of coverage, the  
11 director shall notify the health care services organization. In the notice,  
12 the director shall specify the reasons for the director's disapproval. The  
13 director shall grant a hearing on such disapproval within fifteen days after  
14 a request for a hearing in writing is received from the health care services  
15 organization.

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

42           I. A health care plan that provides coverage for surgical services for  
43 a mastectomy shall also provide coverage incidental to the patient's covered  
44 mastectomy for surgical services for reconstruction of the breast on which  
45 the mastectomy was performed, surgery and reconstruction of the other breast

1 to produce a symmetrical appearance, prostheses, treatment of physical  
2 complications for all stages of the mastectomy, including lymphedemas, and at  
3 least two external postoperative prostheses subject to all of the terms and  
4 conditions of the policy.

5 ~~J. A contract that provides coverage for surgical services for a~~  
6 ~~mastectomy shall also provide coverage for mammography screening performed on~~  
7 ~~dedicated equipment for diagnostic purposes on referral by a patient's~~  
8 ~~physician, subject to all of the terms and conditions of the policy and~~  
9 ~~according to the following guidelines:~~

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

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

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

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

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

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

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

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

28 ~~L.~~ K. The coverage prescribed by subsection ~~K~~ J of this section is  
29 excess to any other coverage the natural mother may have for maternity  
30 benefits except coverage made available to persons pursuant to title 36,  
31 chapter 29 but not including coverage made available to persons defined as  
32 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)  
33 and (e). If such other coverage exists, the agency, attorney or individual  
34 arranging the adoption shall make arrangements for the insurance to pay those  
35 costs that may be covered under that policy and shall advise the adopting  
36 parent in writing of the existence and extent of the coverage without  
37 disclosing any confidential information such as the identity of the natural  
38 parent. The enrollee adopting parents shall notify their health care  
39 services organization of the existence and extent of the other coverage. A  
40 health care services organization is not required to pay any costs in excess  
41 of the amounts it would have been obligated to pay to its hospitals and  
42 providers if the natural mother and child had received the maternity and  
43 newborn care directly from or through that health care services organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

8           ~~P.~~ P. The director shall adopt emergency rules THAT ARE applicable to  
9 persons who are leaving active service in the armed forces of the United  
10 States and returning to civilian status consistent with ~~the provisions of~~  
11 subsection ~~P- 0~~ of this section ~~including~~ AND THAT INCLUDE:

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

23           ~~R.~~ Q. Any contract that provides maternity benefits shall not  
24 restrict benefits for any hospital length of stay in connection with  
25 childbirth for the mother or the newborn child to less than forty-eight hours  
26 following a normal vaginal delivery or ninety-six hours following a cesarean  
27 section. The contract shall not require the provider to obtain authorization  
28 from the health care services organization for prescribing the minimum length  
29 of stay required by this subsection. The contract may provide that an  
30 attending provider in consultation with the mother may discharge the mother  
31 or the newborn child before the expiration of the minimum length of stay  
32 required by this subsection. The health care services organization shall  
33 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 ~~S~~ R 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           ~~S~~ R. Nothing in subsection ~~R~~ Q 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 a health care services organization from imposing  
9 deductibles, coinsurance or other cost sharing in relation to benefits for  
10 hospital lengths of stay in connection with childbirth for a mother or a  
11 newborn child under the contract, except that any coinsurance or other cost  
12 sharing for any portion of a period within a hospital length of stay required  
13 pursuant to subsection ~~R~~ Q of this section shall not be greater than the  
14 coinsurance or cost sharing for any preceding portion of that stay.

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

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

22           1. Blood glucose monitors.

23           2. Blood glucose monitors for the legally blind.

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

26           4. Insulin preparations and glucagon.

27           5. Insulin cartridges.

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

29           7. Injection aids.

30           8. Insulin cartridges for the legally blind.

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

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

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

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

40           ~~U~~ T. Nothing in subsection ~~T~~ S of this section:

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

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

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

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

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

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

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

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

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

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

42           ~~W~~ V. For the purposes of subsection ~~V~~ U of this section:

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

1 (a) The American medical association drug evaluations, a publication  
2 of the American medical association.

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

5 (c) Drug information for the health care provider, a publication of  
6 the United States pharmacopoeia convention.

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

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

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

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

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

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

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

11 ~~Z.~~ Y. The metabolic disorders triggering medical foods coverage under  
12 this section shall:

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

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

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

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

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

28 ~~BB.~~ AA. A health care services organization shall cover at least  
29 fifty per cent of the cost of medical foods prescribed to treat inherited  
30 metabolic disorders and covered pursuant to this section. An organization  
31 may limit the maximum annual benefit for medical foods under this section to  
32 five thousand dollars, which applies to the cost of all prescribed modified  
33 low protein foods and metabolic formula.

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

37 ~~DD.~~ CC. For the purposes of:

38 1. This section:

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

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

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

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

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

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

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

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

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

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 B of this section, "child", for purposes of initial  
27 coverage of an adopted child or a child placed for adoption but not for  
28 purposes of termination of coverage of such child, means a person under ~~the~~  
29 ~~age of~~ eighteen years **OF AGE**.

30 Sec. 4. Title 20, chapter 4, article 9, Arizona Revised Statutes, is  
31 amended by adding section 20-1057.11, to read:

32 **20-1057.11. Health care services organizations; cancer**  
33 **screening examinations; coverage**

34 **ANY CONTRACT OR EVIDENCE OF COVERAGE THAT IS OFFERED BY A HEALTH CARE**  
35 **SERVICES CORPORATION SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER**  
36 **SCREENING EXAMINATIONS ON REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL**  
37 **THE TERMS AND CONDITIONS OF THE CONTRACT OR EVIDENCE OF COVERAGE AND**  
38 **ACCORDING TO THE FOLLOWING GUIDELINES:**

39 **1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST**  
40 **FIFTY YEARS OF AGE:**

41 **(a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.**

42 **(b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.**

43 **(c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.**

44 **(d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY**  
45 **TEN YEARS.**

- 1           2. "MAMMOGRAPHY SCREENING:  
2           (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS  
3 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.  
4           (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF  
5 AGE.  
6           3. BREAST CANCER SCREENING:  
7           (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH  
8 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE  
9 BUT WHO IS UNDER FORTY YEARS OF AGE.  
10          (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST  
11 FORTY YEARS OF AGE.  
12          4. CERVICAL CANCER SCREENING:  
13          (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS  
14 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A  
15 LIQUID-BASED PAP TEST.  
16          (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD  
17 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILLOMAVIRUS TEST AND A  
18 PAP TEST OR LIQUID-BASED PAP TEST.  
19          (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILLOMAVIRUS.  
20          5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT  
21 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL  
22 BIOPSY.  
23          6. PROSTATE CANCER SCREENING:  
24          (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY  
25 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.  
26          (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT  
27 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST  
28 AND A DIGITAL RECTAL EXAMINATION.  
29          Sec. 5. Section 20-1342, Arizona Revised Statutes, is amended to read:  
30          20-1342. Scope and format of policy; definitions  
31          A. A policy of disability insurance shall not be delivered or issued  
32 for delivery to any person in this state unless it otherwise complies with  
33 this title and complies with the following:  
34           1. The entire money and other considerations shall be expressed in the  
35 policy.  
36           2. The time when the insurance takes effect and terminates shall be  
37 expressed in the policy.  
38           3. It shall purport to insure only one person, except that a policy  
39 may insure, originally or by subsequent amendment, on the application of the  
40 policyholder or the policyholder's spouse, any two or more eligible members  
41 of that family, including husband, wife, dependent children or any children  
42 under a specified age that does not exceed nineteen years and any other  
43 person dependent upon the policyholder. Any policy, except accidental death  
44 and dismemberment, applied for that provides family coverage ~~shall~~, as to  
45 such coverage of family members, **SHALL** also provide that the benefits

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

16 4. The style, arrangement and overall appearance of the policy shall  
17 give no undue prominence to any portion of the text, and every printed  
18 portion of the text of the policy and of any endorsements or attached papers  
19 shall be plainly printed in light-faced type of a style in general use, the  
20 size of which shall be uniform and not less than ten point with a lower case  
21 unspaced alphabet length of not less than one hundred and twenty point.  
22 "Text" shall include all printed matter except the name and address of the  
23 insurer, name or title of the policy, the brief description, if any, and  
24 captions and subcaptions.

25 5. The exceptions and reductions of indemnity shall be set forth in  
26 the policy and, other than those contained in sections 20-1345 through  
27 20-1368, shall be printed and, at the insurer's option, either included with  
28 the benefit provision to which they apply or under an appropriate caption  
29 such as "exceptions", or "exceptions and reductions", except that if an  
30 exception or reduction specifically applies only to a particular benefit of  
31 the policy, a statement of such exception or reduction shall be included with  
32 the benefit provision to which it applies.

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

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

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

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

44 (b) For any home health services that are performed by a licensed home  
45 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 9. A 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 ~~10. 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 ~~11.~~ 10. 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 ~~12.~~ 11. The coverage prescribed by paragraph ~~11~~ 10 of this subsection  
42 is excess to any other coverage the natural mother may have for maternity  
43 benefits except coverage made available to persons pursuant to title 36,  
44 chapter 29, but not including coverage made available to persons defined as  
45 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)



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

8 B. 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  
12 section. The contract shall not require the provider to obtain authorization  
13 from the insurer for prescribing the minimum length of stay required by this  
14 subsection. The contract 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 contract  
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 contract 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 contract 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  
40 contract, except that any coinsurance or other cost sharing for any portion  
41 of a period within a hospital length of stay required pursuant to subsection  
42 B of this section shall not be greater than the coinsurance or cost sharing  
43 for any 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 subsection  
3 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:

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

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

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

43           1. Require coverage of any prescription drug used in the treatment of  
44 a type of cancer if the United States food and drug administration has

1 determined that the prescription drug is contraindicated for that type of  
2 cancer.

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

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

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

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

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

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

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

22 (a) The American medical association drug evaluations, a publication  
23 of the American medical association.

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

26 (c) Drug information for the health care provider, a publication of  
27 the United States pharmacopoeia convention.

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)).

44 H. Any contract that is offered by a disability insurer and that  
45 contains a routine outpatient prescription drug benefit shall provide

1 coverage of medical foods to treat inherited metabolic disorders as provided  
2 by this section.

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

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

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

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

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

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

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

26 L. For the purposes of:

27 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

19 Sec. 6. Title 20, chapter 6, article 4, Arizona Revised Statutes, is  
20 amended by adding section 20-1342.06, to read:

21 20-1342.06. Disability insurers; cancer screening examinations;  
22 coverage

23 ANY POLICY OF DISABILITY INSURANCE THAT IS OFFERED BY A DISABILITY  
24 INSURER SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER SCREENING  
25 EXAMINATIONS ON REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL THE TERMS  
26 AND CONDITIONS OF THE POLICY AND ACCORDING TO THE FOLLOWING GUIDELINES:

27 1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST  
28 FIFTY YEARS OF AGE:

- 29 (a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.
- 30 (b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.
- 31 (c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.
- 32 (d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY  
33 TEN YEARS.

34 2. MAMMOGRAPHY SCREENING:

- 35 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS  
36 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.
- 37 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF  
38 AGE.

39 3. BREAST CANCER SCREENING:

- 40 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH  
41 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE  
42 BUT WHO IS UNDER FORTY YEARS OF AGE.
- 43 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST  
44 FORTY YEARS OF AGE.

45 4. CERVICAL CANCER SCREENING:

1 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS  
2 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A  
3 LIQUID-BASED PAP TEST.

4 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD  
5 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILLOMAVIRUS TEST AND A  
6 PAP TEST OR LIQUID-BASED PAP TEST.

7 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILLOMAVIRUS.

8 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT  
9 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL  
10 BIOPSY.

11 6. PROSTATE CANCER SCREENING:

12 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY  
13 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.

14 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT  
15 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST  
16 AND A DIGITAL RECTAL EXAMINATION.

17 Sec. 7. Section 20-1402, Arizona Revised Statutes, is amended to read:  
18 20-1402. Provisions of group disability policies; definitions

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

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

28 2. A provision that the insurer will furnish to the policyholder, for  
29 delivery to each employee or member of the insured group, an individual  
30 certificate setting forth in summary form a statement of the essential  
31 features of the insurance coverage of the employee or member and to whom  
32 benefits are payable. If dependents or family members are included in the  
33 coverage, additional certificates need not be issued for delivery to the  
34 dependents or family members. Any policy, except accidental death and  
35 dismemberment, applied for that provides family coverage ~~shall~~, as to such  
36 coverage of family members, **SHALL** also provide that the benefits applicable  
37 for children shall be payable with respect to a newly born child of the  
38 insured from the instant of such child's birth, to a child adopted by the  
39 insured, regardless of the age at which the child was adopted, and to a child  
40 who has been placed for adoption with the insured and for whom the  
41 application and approval procedures for adoption pursuant to section 8-105 or  
42 8-108 have been completed to the same extent that such coverage applies to  
43 other members of the family. The coverage for newly born or adopted children  
44 or children placed for adoption shall include coverage of injury or sickness,  
45 including the necessary care and treatment of medically diagnosed congenital

1 defects and birth abnormalities. If payment of a specific premium is  
2 required to provide coverage for a child, the policy may require that  
3 notification of birth, adoption or adoption placement of the child and  
4 payment of the required premium must be furnished to the insurer within  
5 thirty-one days after the date of birth, adoption or adoption placement in  
6 order to have the coverage continue beyond such thirty-one day period.

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

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

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

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

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

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

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

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

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

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

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

44 ~~7.~~ 6. Any contract that is issued to the insured and that provides  
45 coverage for maternity benefits shall also provide that the maternity

1 benefits apply to the costs of the birth of any child legally adopted by the  
2 insured if all the following are true:

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

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

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

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

11 ~~8-~~ 7. The coverage prescribed by paragraph ~~7-~~ 6 of this subsection is  
12 excess to any other coverage the natural mother may have for maternity  
13 benefits except coverage made available to persons pursuant to title 36,  
14 chapter 29, but not including coverage made available to persons defined as  
15 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)  
16 and (e). If such other coverage exists, the agency, attorney or individual  
17 arranging the adoption shall make arrangements for the insurance to pay those  
18 costs that may be covered under that policy and shall advise the adopting  
19 parent in writing of the existence and extent of the coverage without  
20 disclosing any confidential information such as the identity of the natural  
21 parent. The insured adopting parents shall notify their insurer of the  
22 existence and extent of the other coverage.

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

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

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

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

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



1           5. Except as described in subsection C 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           C. Nothing in subsection B 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 policy,  
11 except that any coinsurance or other cost sharing for any portion of a period  
12 within a hospital length of stay required pursuant to subsection B of this  
13 section shall not be greater than the coinsurance or cost sharing for any  
14 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  
17 subsection B of this section.

18           D. 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           E. Nothing in subsection D of this section prohibits a group  
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           F. 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 G of this  
6 section or medical literature that meets the criteria prescribed in  
7 subsection G 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 G. For the purposes of subsection F of this section:

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

33 (a) The American medical association drug evaluations, a publication  
34 of the American medical association.

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

37 (c) Drug information for the health care provider, a publication of  
38 the United States pharmacopoeia convention.

39 2. Medical literature may be accepted if all of the following 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 which  
43 the drug has been prescribed.

44 (b) No article from a major peer reviewed professional medical journal  
45 has concluded, based on scientific or medical criteria, that the drug is

1 unsafe or ineffective or that the drug's safety and effectiveness cannot be  
2 determined for the treatment of the indication for which the drug has been  
3 prescribed.

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

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

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

15 1. Be part of the newborn screening program prescribed in section  
16 36-694.

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

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

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

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

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

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

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

1 deductibles, coinsurance, copayments or other cost containment measures for  
2 other drugs on the same level of the formulary or list.

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

9 M. Notwithstanding subsection L of this section, a religious employer  
10 whose religious tenets prohibit the use of prescribed contraceptive methods  
11 may require that the insurer provide a group disability policy without  
12 coverage for all ~~federal~~ UNITED STATES food and drug administration approved  
13 contraceptive methods. A religious employer shall submit a written affidavit  
14 to the insurer stating that it is a religious employer. On receipt of the  
15 affidavit, the insurer shall issue to the religious employer a group  
16 disability policy that excludes coverage of prescription contraceptive  
17 methods. The insurer shall retain the affidavit for the duration of the  
18 group disability policy and any renewals of the policy. Before a policy is  
19 issued, every religious employer that invokes this exemption shall provide  
20 prospective insureds written notice that the religious employer refuses to  
21 cover all ~~federal~~ UNITED STATES food and drug administration approved  
22 contraceptive methods for religious reasons. This subsection shall not  
23 exclude coverage for prescription contraceptive methods ordered by a health  
24 care provider with prescriptive authority for medical indications other than  
25 to prevent an unintended pregnancy. An insurer may require the insured to  
26 first pay for the prescription and then submit a claim to the insurer along  
27 with evidence that the prescription is for a noncontraceptive purpose. An  
28 insurer may charge an administrative fee for handling these claims. A  
29 religious employer shall not discriminate against an employee who  
30 independently chooses to obtain insurance coverage or prescriptions for  
31 contraceptives from another source.

32 N. For the purposes of:

33 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

21 2. Subsection A of this section, ~~the term~~ "child", for purposes of  
22 initial coverage of an adopted child or a child placed for adoption but not  
23 for purposes of termination of coverage of such child, means a person under  
24 ~~the age of~~ eighteen years **OF AGE**.

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

27 (a) The entity primarily employs persons who share the religious  
28 tenets of the entity.

29 (b) The entity serves primarily persons who share the religious tenets  
30 of the entity.

31 (c) The entity is a nonprofit organization as described in section  
32 6033(a)(2)(A) ~~+~~ (i) or ~~+++~~ (iii) of the internal revenue code of 1986, as  
33 amended.

34 Sec. 8. Title 20, chapter 6, article 5, Arizona Revised Statutes, is  
35 amended by adding section 20-1402.03, to read:

36 **20-1402.03. Group disability insurers; cancer screening**  
37 **examinations; coverage**

38 **ANY GROUP DISABILITY POLICY THAT IS OFFERED BY A GROUP DISABILITY**  
39 **INSURER SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER SCREENING**  
40 **EXAMINATIONS ON REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL THE TERMS**  
41 **AND CONDITIONS OF THE POLICY AND ACCORDING TO THE FOLLOWING GUIDELINES:**

42 **1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST**  
43 **FIFTY YEARS OF AGE:**

44 **(a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.**

45 **(b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.**

- 1 (c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.  
2 (d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY  
3 TEN YEARS.
- 4 2. MAMMOGRAPHY SCREENING:  
5 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS  
6 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.  
7 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF  
8 AGE.
- 9 3. BREAST CANCER SCREENING:  
10 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH  
11 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE  
12 BUT WHO IS UNDER FORTY YEARS OF AGE.  
13 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST  
14 FORTY YEARS OF AGE.
- 15 4. CERVICAL CANCER SCREENING:  
16 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS  
17 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A  
18 LIQUID-BASED PAP TEST.  
19 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD  
20 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILLOMAVIRUS TEST AND A  
21 PAP TEST OR LIQUID-BASED PAP TEST.  
22 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILLOMAVIRUS.
- 23 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT  
24 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL  
25 BIOPSY.
- 26 6. PROSTATE CANCER SCREENING:  
27 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY  
28 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.  
29 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT  
30 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST  
31 AND A DIGITAL RECTAL EXAMINATION.
- 32 Sec. 9. Section 20-1404, Arizona Revised Statutes, is amended to read:  
33 20-1404. Blanket disability insurance; definitions  
34 A. Blanket disability insurance is that form of disability insurance  
35 covering special groups of persons as enumerated in one of the following  
36 paragraphs:  
37 1. Under a policy or contract issued to any common carrier, which  
38 shall be deemed the policyholder, covering a group defined as all persons who  
39 may become passengers on such common carrier.  
40 2. Under a policy or contract issued to an employer, who shall be  
41 deemed the policyholder, covering all employees or any group of employees  
42 defined by reference to exceptional hazards incident to such employment.  
43 Dependents of the employees and guests of the employer may also be included  
44 where exposed to the same hazards.

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

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

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

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

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

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

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

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

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

1 coverage for a child, the policy or contract may require that notification of  
2 birth, adoption or adoption placement of the child and payment of the  
3 required premium must be furnished to the insurer within thirty-one days  
4 after the date of birth, adoption or adoption placement in order to have the  
5 coverage continue beyond the thirty-one day period.

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

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

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

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

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

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

28 ~~H. A contract that provides coverage for surgical services for a~~  
29 ~~mastectomy shall also provide coverage for mammography screening performed on~~  
30 ~~dedicated equipment for diagnostic purposes on referral by a patient's~~  
31 ~~physician, subject to all of the terms and conditions of the policy and~~  
32 ~~according to the following guidelines:~~

33 ~~1. A baseline mammogram for a woman from age thirty five to~~  
34 ~~thirty nine.~~

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

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

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

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

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



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

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

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

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

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

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

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

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

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

44           ~~L~~ K. Nothing in subsection ~~K~~ J of this section:

- 1           1. Requires a mother to give birth in a hospital or to stay in the  
2 hospital for a fixed period of time following the birth of the child.
- 3           2. Prevents an insurer from imposing deductibles, coinsurance or other  
4 cost sharing in relation to benefits for hospital lengths of stay in  
5 connection with childbirth for a mother or a newborn child under the  
6 contract, except that any coinsurance or other cost sharing for any portion  
7 of a period within a hospital length of stay required pursuant to subsection  
8 ~~K~~ J of this section shall not be greater than the coinsurance or cost  
9 sharing for any preceding portion of that stay.
- 10          3. Prevents an insurer from negotiating the level and type of  
11 reimbursement with a provider for care provided in accordance with subsection  
12 ~~K~~ J of this section.
- 13           ~~M~~ L. Any contract that provides coverage for diabetes shall also  
14 provide coverage for equipment and supplies that are medically necessary and  
15 that are prescribed by a health care provider, including:
- 16           1. Blood glucose monitors.  
17           2. Blood glucose monitors for the legally blind.  
18           3. Test strips for glucose monitors and visual reading and urine  
19 testing strips.  
20           4. Insulin preparations and glucagon.  
21           5. Insulin cartridges.  
22           6. Drawing up devices and monitors for the visually impaired.  
23           7. Injection aids.  
24           8. Insulin cartridges for the legally blind.  
25           9. Syringes and lancets, including automatic lancing devices.  
26           10. Prescribed oral agents for controlling blood sugar that are  
27 included on the plan formulary.  
28           11. To the extent coverage is required under medicare, podiatric  
29 appliances for prevention of complications associated with diabetes.  
30           12. Any other device, medication, equipment or supply for which  
31 coverage is required under medicare from and after January 1, 1999. The  
32 coverage required in this paragraph is effective six months after the  
33 coverage is required under medicare.
- 34           ~~N~~ M. Nothing in subsection ~~M~~ L of this section prohibits a blanket  
35 disability insurer from imposing deductibles, coinsurance or other cost  
36 sharing in relation to benefits for equipment or supplies for the treatment  
37 of diabetes.
- 38           ~~O~~ N. Any contract that provides coverage for prescription drugs  
39 shall not limit or exclude coverage for any prescription drug prescribed for  
40 the treatment of cancer on the basis that the prescription drug has not been  
41 approved by the United States food and drug administration for the treatment  
42 of the specific type of cancer for which the prescription drug has been  
43 prescribed, if the prescription drug has been recognized as safe and  
44 effective for treatment of that specific type of cancer in one or more of the  
45 standard medical reference compendia prescribed in subsection ~~P~~ O of this

1 section or medical literature that meets the criteria prescribed in  
2 subsection ~~P~~- 0 of this section. The coverage required under this subsection  
3 includes covered medically necessary services associated with the  
4 administration of the prescription drug. This subsection does not:

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

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

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

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

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

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

25 ~~P~~- 0. For the purposes of subsection ~~0~~- N of this section:

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

28 (a) The American medical association drug evaluations, a publication  
29 of the American medical association.

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

32 (c) Drug information for the health care provider, a publication of  
33 the United States pharmacopoeia convention.

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

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

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

44 (c) The literature meets the uniform requirements for manuscripts  
45 submitted to biomedical journals established by the international committee

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

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

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

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

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

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

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

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

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

32 ~~U.~~ T. Any blanket disability policy that provides coverage for:

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

43 2. Outpatient health care services shall also provide coverage for  
44 outpatient contraceptive services. For the purposes of this paragraph,  
45 "outpatient contraceptive services" means consultations, examinations,

1 procedures and medical services provided on an outpatient basis and related  
2 to the use of APPROVED United States food and drug ADMINISTRATION  
3 prescription contraceptive methods to prevent unintended pregnancies.

4 ~~V.~~ U. Notwithstanding subsection ~~U.~~ T of this section, a religious  
5 employer whose religious tenets prohibit the use of prescribed contraceptive  
6 methods may require that the insurer provide a blanket disability policy  
7 without coverage for all ~~federal~~ UNITED STATES food and drug administration  
8 approved contraceptive methods. A religious employer shall submit a written  
9 affidavit to the insurer stating that it is a religious employer. On receipt  
10 of the affidavit, the insurer shall issue to the religious employer a blanket  
11 disability policy that excludes coverage of prescription contraceptive  
12 methods. The insurer shall retain the affidavit for the duration of the  
13 blanket disability policy and any renewals of the policy. Before a policy is  
14 issued, every religious employer that invokes this exemption shall provide  
15 prospective insureds written notice that the religious employer refuses to  
16 cover all ~~federal~~ UNITED STATES food and drug administration approved  
17 contraceptive methods for religious reasons. This subsection shall not  
18 exclude coverage for prescription contraceptive methods ordered by a health  
19 care provider with prescriptive authority for medical indications other than  
20 to prevent an unintended pregnancy. An insurer may require the insured to  
21 first pay for the prescription and then submit a claim to the insurer along  
22 with evidence that the prescription is for a noncontraceptive purpose. An  
23 insurer may charge an administrative fee for handling these claims under this  
24 ~~paragraph~~ SUBSECTION. A religious employer shall not discriminate against an  
25 employee who independently chooses to obtain insurance coverage or  
26 prescriptions for contraceptives from another source.

27 ~~W.~~ V. For the purposes of:

28 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (a) The entity primarily employs persons who share the religious  
22 tenets of the entity.

23 (b) The entity serves primarily persons who share the religious tenets  
24 of the entity.

25 (c) 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  
27 amended.

28 Sec. 10. Title 20, chapter 6, article 5, Arizona Revised Statutes, is  
29 amended by adding section 20-1404.03, to read:

30 20-1404.03. Blanket disability insurers: cancer screening  
31 examinations: coverage

32 ANY POLICY OR CONTRACT THAT IS OFFERED BY A BLANKET DISABILITY INSURER  
33 SHALL PROVIDE COVERAGE FOR THE FOLLOWING CANCER SCREENING EXAMINATIONS ON  
34 REFERRAL BY A PATIENT'S PHYSICIAN, SUBJECT TO ALL THE TERMS AND CONDITIONS OF  
35 THE POLICY OR CONTRACT AND ACCORDING TO THE FOLLOWING GUIDELINES:

36 1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST  
37 FIFTY YEARS OF AGE:

38 (a) A YEARLY FECAL OCCULT BLOOD TEST OR FECAL IMMUNOCHEMICAL TEST.

39 (b) A FLEXIBLE SIGMOIDOSCOPY PROCEDURE EVERY FIVE YEARS.

40 (c) A DOUBLE-CONTRAST BARIUM ENEMA EVERY FIVE YEARS.

41 (d) A COLONOSCOPY PROCEDURE OR A VIRTUAL COLONOSCOPY PROCEDURE EVERY  
42 TEN YEARS.

43 2. MAMMOGRAPHY SCREENING:

44 (a) A BASELINE MAMMOGRAM FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS  
45 OF AGE BUT WHO IS UNDER FORTY YEARS OF AGE.

1 (b) A MAMMOGRAM EVERY YEAR FOR A WOMAN WHO IS AT LEAST FORTY YEARS OF  
2 AGE.

3 3. BREAST CANCER SCREENING:

4 (a) A CLINICAL BREAST EXAMINATION AS PART OF A PERIODIC HEALTH  
5 EXAMINATION EVERY THREE YEARS FOR A WOMAN WHO IS AT LEAST TWENTY YEARS OF AGE  
6 BUT WHO IS UNDER FORTY YEARS OF AGE.

7 (b) A YEARLY CLINICAL BREAST EXAMINATION FOR A WOMAN WHO IS AT LEAST  
8 FORTY YEARS OF AGE.

9 4. CERVICAL CANCER SCREENING:

10 (a) FOR A WOMAN WHO IS AT LEAST TWENTY-ONE YEARS OF AGE BUT WHO IS  
11 UNDER THIRTY YEARS OF AGE, A YEARLY PAP TEST, OR EVERY TWO YEARS, A  
12 LIQUID-BASED PAP TEST.

13 (b) FOR A WOMAN WHO IS AT LEAST THIRTY YEARS OF AGE AND WHO HAS HAD  
14 THREE NORMAL PAP TESTS, EVERY THREE YEARS THE HUMAN PAPILOMAVIRUS TEST AND A  
15 PAP TEST OR LIQUID-BASED PAP TEST.

16 (c) ANY MEDICATION OR VACCINE TO TREAT THE HUMAN PAPILOMAVIRUS.

17 5. FOR A WOMAN WHO IS AT LEAST THIRTY-FIVE YEARS OF AGE AND WHO IS AT  
18 HIGH RISK FOR HEREDITARY NONPOLYPOSIS COLON CANCER, AN ANNUAL ENDOMETRIAL  
19 BIOPSY.

20 6. PROSTATE CANCER SCREENING:

21 (a) FOR A MAN WHO IS AT LEAST FIFTY YEARS OF AGE, A YEARLY  
22 PROSTATE-SPECIFIC ANTIGEN BLOOD TEST AND A DIGITAL RECTAL EXAMINATION.

23 (b) FOR A MAN WHO IS AT HIGH RISK FOR PROSTATE CANCER AND WHO IS AT  
24 LEAST FORTY-FIVE YEARS OF AGE, A YEARLY PROSTATE-SPECIFIC ANTIGEN BLOOD TEST  
25 AND A DIGITAL RECTAL EXAMINATION.

26 Sec. 11. Section 20-2318, Arizona Revised Statutes, is amended to  
27 read:

28 20-2318. Mandatory coverage prohibited

29 Notwithstanding any law to the contrary, the basic health benefit plan  
30 is not subject to the requirements of:

- 31 1. Section 20-461, subsection A, paragraph ~~16~~ 17 and subsection B. ~~---~~
- 32 2. Section 20-826, subsections C, D, E, F, H, I, ~~---~~ AND J. ~~and K,~~
- 33 3. SECTION 20-826.04.
- 34 4. ~~Sections~~ SECTION 20-841. ~~---~~
- 35 5. SECTION 20-841.01. ~~and~~
- 36 6. SECTION 20-841.02. ~~---~~
- 37 7. Section 20-1051, paragraph 4. ~~---~~
- 38 8. Section 20-1057, subsections B, C, I, J, K, ~~---~~ AND L. ~~and M,~~
- 39 9. SECTION 20-1057.11.
- 40 10. Section 20-1402, subsection A, paragraphs 2, 4, 5, 6, ~~---~~ AND 7.
- 41 ~~and 8,~~
- 42 11. SECTION 20-1402.03.
- 43 12. Section 20-1404, subsections E, F, G, H, ~~---~~ AND I. ~~and J and~~
- 44 13. SECTION 20-1404.03.
- 45 14. ~~Sections~~ SECTION 20-1406. ~~---~~





1           2. "Small business" means a business that employed at least two but  
2 not more than twenty-five persons at any time during the most recent calendar  
3 year and that has been uninsured for at least six months.

4           Sec. 13. Application

5           This act applies to contracts, policies and evidences of coverage  
6 issued or renewed from and after December 31, 2007.