

Senate Engrossed House Bill

**FILED**

**KEN BENNETT**

**SECRETARY OF STATE**

State of Arizona  
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First Regular Session  
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CHAPTER 39

# **HOUSE BILL 2145**

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1379, 20-1402, 20-1404 AND  
20-2326, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

31 E. Any contract, except accidental death and dismemberment, applied  
32 for that provides family coverage ~~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,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35          1. Conditions of eligibility.

36          2. Coverage of dependents.

37          3. Preexisting conditions.

38          4. Termination of insurance.

39          5. Probationary periods.

40          6. Limitations.

41          7. Exceptions.

42          8. Reductions.

43          9. Elimination periods.

44          10. Requirements for replacement.

1           11. Any other condition of subscription contracts.

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

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

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

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

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

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

28           O. Nothing in subsection N of this section:

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

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

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

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

44           1. Blood glucose monitors.

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

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

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

16           ~~(b)~~ (a) 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           (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
21 COMPENDIUM.

22           (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

23           (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

24           (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
25 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

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

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

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

42           T. A corporation shall not issue or deliver any advertising matter or  
43 sales material to any person in this state until the corporation files the  
44 advertising matter or sales material with the director. This subsection does

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

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

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

30 1. Be part of the newborn screening program prescribed in section  
31 36-694.

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

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

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

42 W. Medical foods eligible for coverage under this section shall be  
43 prescribed or ordered under the supervision of a physician licensed pursuant

1 to title 32, chapter 13 or 17 as medically necessary for the therapeutic  
2 treatment of an inherited metabolic disease.

3 X. A hospital service corporation or medical service corporation shall  
4 cover at least fifty per cent of the cost of medical foods prescribed to  
5 treat inherited metabolic disorders and covered pursuant to this section. A  
6 hospital service corporation or medical service corporation may limit the  
7 maximum annual benefit for medical foods under this section to five thousand  
8 dollars, which applies to the cost of all prescribed modified low protein  
9 foods and metabolic formula.

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

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

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

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

32 Z. Notwithstanding subsection Y of this section, a religious employer  
33 whose religious tenets prohibit the use of prescribed contraceptive methods  
34 may require that the corporation provide a contract without coverage for all  
35 United States food and drug administration approved contraceptive methods. A  
36 religious employer shall submit a written affidavit to the corporation  
37 stating that it is a religious employer. On receipt of the affidavit, the  
38 corporation shall issue to the religious employer a contract that excludes  
39 coverage of prescription contraceptive methods. The corporation shall retain  
40 the affidavit for the duration of the contract and any renewals of the  
41 contract. Before enrollment in the plan, every religious employer that  
42 invokes this exemption shall provide prospective subscribers written notice  
43 that the religious employer refuses to cover all United States food and drug  
44 administration approved contraceptive methods for religious reasons. This

1 subsection shall not exclude coverage for prescription contraceptive methods  
2 ordered by a health care provider with prescriptive authority for medical  
3 indications other than to prevent an unintended pregnancy. A corporation may  
4 require the subscriber to first pay for the prescription and then submit a  
5 claim to the corporation along with evidence that the prescription is for a  
6 noncontraceptive purpose. A corporation may charge an administrative fee for  
7 handling these claims. A religious employer shall not discriminate against  
8 an employee who independently chooses to obtain insurance coverage or  
9 prescriptions for contraceptives from another source.

10 AA. For the purposes of:

11 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

43 2. Subsection E of this section, the term "child", for purposes of  
44 initial coverage of an adopted child or a child placed for adoption but not

1 for purposes of termination of coverage of such child, means a person under  
2 the age of eighteen years.

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

5 (a) The entity primarily employs persons who share the religious  
6 tenets of the entity.

7 (b) The entity primarily serves persons who share the religious tenets  
8 of the entity.

9 (c) The entity is a nonprofit organization as described in section  
10 6033(a)(2)(A) (i) or (iii) of the internal revenue code of 1986, as amended.

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

12 20-1057. Evidence of coverage by health care services  
13 organizations; renewability; definitions

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

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

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

40 D. No evidence of coverage or amendment to the coverage shall be  
41 issued or delivered to any person in this state until a copy of the form of  
42 the evidence of coverage or amendment to the coverage has been filed with and  
43 approved by the director.

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

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

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

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

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

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

15          G. The director shall approve any form of evidence of coverage if the  
16 requirements of subsections E and F of this section are met. It is unlawful  
17 to issue such form until approved. If the director does not disapprove any  
18 such form within forty-five days after the filing of the form, it is deemed  
19 approved. If the director disapproves a form of evidence of coverage, the  
20 director shall notify the health care services organization. In the notice,  
21 the director shall specify the reasons for the director's disapproval. The  
22 director shall grant a hearing on such disapproval within fifteen days after  
23 a request for a hearing in writing is received from the health care services  
24 organization.

25          H. A health care services organization shall not cancel or refuse to  
26 renew an enrollee's evidence of coverage that was issued on a group basis  
27 without giving notice of the cancellation or nonrenewal to the enrollee and,  
28 on request of the director, to the department of insurance. A notice by the  
29 organization to the enrollee of cancellation or nonrenewal of the enrollee's  
30 evidence of coverage shall be mailed to the enrollee at least sixty days  
31 before the effective date of such cancellation or nonrenewal. The notice  
32 shall include or be accompanied by a statement in writing of the reasons as  
33 stated in the contract for such action by the organization. Failure of the  
34 organization to comply with this subsection shall invalidate any cancellation  
35 or nonrenewal except a cancellation or nonrenewal for nonpayment of premium,  
36 for fraud or misrepresentation in the application or other enrollment  
37 documents or for loss of eligibility as defined in the evidence of coverage.  
38 A health care services organization shall not cancel an enrollee's evidence  
39 of coverage issued on a group basis because of the enrollee's or dependent's  
40 age, except for loss of eligibility as defined in the evidence of coverage,  
41 sex, health status-related factor, national origin or frequency of  
42 utilization of health care services of the enrollee. An evidence of coverage  
43 issued on a group basis shall clearly delineate all terms under which the  
44 health care services organization may cancel or refuse to renew an evidence

1 of coverage for an enrollee or dependent. Nothing in this subsection  
2 prohibits the cancellation or nonrenewal of a health benefits plan contract  
3 issued on a group basis for any of the reasons allowed in section 20-2309. A  
4 health care services organization may cancel or nonrenew an evidence of  
5 coverage issued to an individual on a nongroup basis only for the reasons  
6 allowed by subsection N of this section.

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

15 J. A contract that provides coverage for surgical services for a  
16 mastectomy shall also provide coverage for mammography screening performed on  
17 dedicated equipment for diagnostic purposes on referral by a patient's  
18 physician, subject to all of the terms and conditions of the policy and  
19 according to the following guidelines:

20 1. A baseline mammogram for a woman from age thirty-five to  
21 thirty-nine.

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

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

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

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

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

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

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

38 L. The coverage prescribed by subsection K of this section is excess  
39 to any other coverage the natural mother may have for maternity benefits  
40 except coverage made available to persons pursuant to title 36, chapter 29  
41 but not including coverage made available to persons defined as eligible  
42 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
43 such other coverage exists the agency, attorney or individual arranging the  
44 adoption shall make arrangements for the insurance to pay those costs that

1 may be covered under that policy and shall advise the adopting parent in  
2 writing of the existence and extent of the coverage without disclosing any  
3 confidential information such as the identity of the natural parent. The  
4 enrollee adopting parents shall notify their health care services  
5 organization of the existence and extent of the other coverage. A health  
6 care services organization is not required to pay any costs in excess of the  
7 amounts it would have been obligated to pay to its hospitals and providers if  
8 the natural mother and child had received the maternity and newborn care  
9 directly from or through that health care services organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

18           Q. The director shall adopt emergency rules THAT ARE applicable to  
19 persons who are leaving active service in the armed forces of the United  
20 States and returning to civilian status consistent with subsection P of this  
21 section ~~including~~ AND THAT INCLUDE:

- 22           1. Conditions of eligibility.
- 23           2. Coverage of dependents.
- 24           3. Preexisting conditions.
- 25           4. Termination of insurance.
- 26           5. Probationary periods.
- 27           6. Limitations.
- 28           7. Exceptions.
- 29           8. Reductions.
- 30           9. Elimination periods.
- 31           10. Requirements for replacement.
- 32           11. Any other conditions of evidences of coverage.

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

- 1           1. Deny the mother or the newborn child eligibility or continued  
2 eligibility to enroll or to renew coverage under the terms of the contract  
3 solely for the purpose of avoiding the requirements of this subsection.
- 4           2. Provide monetary payments or rebates to mothers to encourage those  
5 mothers to accept less than the minimum protections available pursuant to  
6 this subsection.
- 7           3. Penalize or otherwise reduce or limit the reimbursement of an  
8 attending provider because that provider provided care to any insured under  
9 the contract in accordance with this subsection.
- 10          4. Provide monetary or other incentives to an attending provider to  
11 induce that provider to provide care to an insured under the contract in a  
12 manner that is inconsistent with this subsection.
- 13          5. Except as described in subsection S of this section, restrict  
14 benefits for any portion of a period within the minimum length of stay in a  
15 manner that is less favorable than the benefits provided for any preceding  
16 portion of that stay.
- 17          5. Nothing in subsection R of this section:
  - 18           1. Requires a mother to give birth in a hospital or to stay in the  
19 hospital for a fixed period of time following the birth of the child.
  - 20           2. Prevents a health care services organization from imposing  
21 deductibles, coinsurance or other cost sharing in relation to benefits for  
22 hospital lengths of stay in connection with childbirth for a mother or a  
23 newborn child under the contract, except that any coinsurance or other cost  
24 sharing for any portion of a period within a hospital length of stay required  
25 pursuant to subsection R of this section shall not be greater than the  
26 coinsurance or cost sharing for any preceding portion of that stay.
  - 27           3. Prevents a health care services organization from negotiating the  
28 level and type of reimbursement with a provider for care provided in  
29 accordance with subsection R of this section.
  - 30           T. Any contract or evidence of coverage that provides coverage for  
31 diabetes shall also provide coverage for equipment and supplies that are  
32 medically necessary and that are prescribed by a health care provider  
33 including:
    - 34           1. Blood glucose monitors.
    - 35           2. Blood glucose monitors for the legally blind.
    - 36           3. Test strips for glucose monitors and visual reading and urine  
37 testing strips.
    - 38           4. Insulin preparations and glucagon.
    - 39           5. Insulin cartridges.
    - 40           6. Drawing up devices and monitors for the visually impaired.
    - 41           7. Injection aids.
    - 42           8. Insulin cartridges for the legally blind.
    - 43           9. Syringes and lancets including automatic lancing devices.

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

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

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

9           U. Nothing in subsection T of this section:

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

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

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

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

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

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

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

42           4. Notwithstanding section 20-1057.02, require reimbursement or  
43 coverage for any prescription drug that is not included in the drug formulary

1 or list of covered prescription drugs specified in the contract or evidence  
2 of coverage.

3 5. Notwithstanding section 20-1057.02, prohibit a contract or evidence  
4 of coverage from limiting or excluding coverage of a prescription drug, if  
5 the decision to limit or exclude coverage of the prescription drug is not  
6 based primarily on the coverage of prescription drugs required by this  
7 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 W. For the purposes of subsection V 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)~~ (a) 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 (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
21 COMPENDIUM.

22 (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

23 (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

24 (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
25 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

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

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

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

42 X. A health care services organization shall not issue or deliver any  
43 advertising matter or sales material to any person in this state until the  
44 health care services organization files the advertising matter or sales

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

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

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

33 1. Be part of the newborn screening program prescribed in section  
34 36-694.

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

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

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

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

6           BB. A health care services organization shall cover at least fifty per  
7 cent of the cost of medical foods prescribed to treat inherited metabolic  
8 disorders and covered pursuant to this section. An organization may limit  
9 the maximum annual benefit for medical foods under this section to five  
10 thousand dollars, which applies to the cost of all prescribed modified low  
11 protein foods and metabolic formula.

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

15           DD. For the purposes of:

16           1. This section:

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

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

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

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

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

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

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

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

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

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

1 (iii) Administered for the medical and nutritional management of a  
2 person who has limited capacity to metabolize foodstuffs or certain 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 2. Subsection B of this section, "child", for purposes of initial  
8 coverage of an adopted child or a child placed for adoption but not for  
9 purposes of termination of coverage of such child, means a person under ~~the~~  
10 ~~age of~~ eighteen years OF AGE.

11 Sec. 3. Section 20-1342, Arizona Revised Statutes, is amended to read:  
12 20-1342. Scope and format of policy; definitions

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

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

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

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

43 4. The style, arrangement and overall appearance of the policy shall  
44 give no undue prominence to any portion of the text, and every printed

1 portion of the text of the policy and of any endorsements or attached papers  
2 shall be plainly printed in light-faced type of a style in general use, the  
3 size of which shall be uniform and not less than ten point with a lower case  
4 unspaced alphabet length of not less than one hundred and twenty point.  
5 "Text" shall include all printed matter except the name and address of the  
6 insurer, name or title of the policy, the brief description, if any, and  
7 captions and subcaptions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25           12. The coverage prescribed by paragraph 11 of this subsection is  
26 excess to any other coverage the natural mother may have for maternity  
27 benefits except coverage made available to persons pursuant to title 36,  
28 chapter 29, but not including coverage made available to persons defined as  
29 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)  
30 and (e). If such other coverage exists the agency, attorney or individual  
31 arranging the adoption shall make arrangements for the insurance to pay those  
32 costs that may be covered under that policy and shall advise the adopting  
33 parent in writing of the existence and extent of the coverage without  
34 disclosing any confidential information such as the identity of the natural  
35 parent. The insured adopting parents shall notify their insurer of the  
36 existence and extent of the other coverage.

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

1 before the expiration of the minimum length of stay required by this  
2 subsection. The insurer shall not:

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

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

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

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

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

19 C. Nothing in subsection B of this section:

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

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

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

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

35 1. Blood glucose monitors.

36 2. Blood glucose monitors for the legally blind.

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

39 4. Insulin preparations and glucagon.

40 5. Insulin cartridges.

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

42 7. Injection aids.

43 8. Insulin cartridges for the legally blind.

44 9. Syringes and lancets including automatic lancing devices.

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

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

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

9           E. Nothing in subsection D of this section:

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

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

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

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

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

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

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

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

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

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

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

7           ~~(a) The American medical association drug evaluations, a publication~~  
8 ~~of the American medical association.~~

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

11           ~~(c) Drug information for the health care provider, a publication of~~  
12 ~~the United States pharmacopoeia convention.~~

13           (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
14 COMPENDIUM.

15           (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

16           (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

17           (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
18 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

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

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

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

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

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

41           1. Be part of the newborn screening program prescribed in section  
42 36-694.

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

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

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

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

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

21          L. For the purposes of:

22           1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

16 Sec. 4. Section 20-1379, Arizona Revised Statutes, is amended to read:  
17 20-1379. Guaranteed availability of individual health insurance  
18 coverage; prior group coverage; definitions

19 A. Every health care insurer that offers individual health insurance  
20 coverage in the individual market in this state shall provide guaranteed  
21 availability of coverage to an eligible individual who desires to enroll in  
22 individual health insurance coverage and shall not:

23 1. Decline to offer that coverage to, or deny enrollment of, that  
24 individual.

25 2. Impose any preexisting condition exclusion for that coverage.

26 B. Every health care insurer that offers individual health insurance  
27 coverage in the individual market in this state shall offer all policy forms  
28 of health insurance coverage that are designed for, THAT are made generally  
29 available and actively marketed to and THAT enroll both eligible or other  
30 individuals. A health care insurer that offers only one policy form in the  
31 individual market complies with this section by offering that form to  
32 eligible individuals. A health care insurer also may comply with the  
33 requirements of this section by electing to offer at least two different  
34 policy forms to eligible individuals as provided by subsection C of this  
35 section.

36 C. A health care insurer shall meet the requirements prescribed in  
37 subsection B of this section if:

38 1. The health care insurer offers at least two different policy forms,  
39 both of which are designed for, ARE made generally available and actively  
40 marketed to and enroll both eligible and other individuals.

41 2. The offer includes at least either:

42 (a) The policy forms with the largest and next to the largest earned  
43 premium volume of all policy forms offered by the health care insurer in this

1 state in the individual market during a period not to exceed the preceding  
2 two calendar years.

3 (b) A choice of two policy forms with representative coverage,  
4 consisting of a lower level of coverage policy form and a higher level of  
5 coverage policy form, each of which includes benefits that are substantially  
6 similar to other individual health insurance coverage offered by the health  
7 care insurer in this state and each of which is covered by a method that  
8 provides for risk adjustment, risk spreading or a risk spreading mechanism  
9 among the health care insurer's policies.

10 D. The health care insurer's election pursuant to subsection C of this  
11 section is effective for policies offered during a period of at least two  
12 years.

13 E. If a health care insurer offers individual health insurance  
14 coverage in the individual market through a network plan, the health care  
15 insurer may do both of the following:

16 1. Limit the individuals who may be enrolled under health insurance  
17 coverage to those who live, reside or work within the service area for a  
18 network plan.

19 2. Within the service area of a network plan, deny health insurance  
20 coverage to individuals if the health care insurer has demonstrated, if  
21 required, to the director that both:

22 (a) The health care insurer will not have the capacity to deliver  
23 services adequately to additional individual enrollees because of the health  
24 care insurer's obligations to existing group contract holders and enrollees  
25 and individual enrollees.

26 (b) The health care insurer is applying this paragraph uniformly to  
27 individuals without regard to any health status-related factor of the  
28 individuals and without regard to whether the individuals are eligible  
29 individuals.

30 F. A health care insurer may deny individual health insurance coverage  
31 in the individual market to an eligible individual if the health care insurer  
32 demonstrates to the director that the health care insurer:

33 1. Does not have the financial reserves necessary to underwrite  
34 additional coverage.

35 2. Is denying coverage uniformly to all individuals in the individual  
36 market in this state pursuant to state law and without regard to any health  
37 status-related factor of the individuals and without regard to whether the  
38 individuals are eligible individuals.

39 G. If a health care insurer denies health insurance coverage in this  
40 state pursuant to subsection F of this section, the health care insurer shall  
41 not offer that coverage in the individual market in this state for one  
42 hundred eighty days after the date the coverage is denied or until the health  
43 care insurer demonstrates to the director that the health care insurer has

1 sufficient financial reserves to underwrite additional coverage, whichever is  
2 later.

3 H. An accountable health plan as defined in section 20-2301 that  
4 offers conversion policies on an individual or group basis in connection with  
5 a health benefits plan pursuant to this title is not a health care insurer  
6 that offers individual health insurance coverage solely because of the offer  
7 of a conversion policy.

8 I. Nothing in this section:

9 1. Creates additional restrictions on the amount of the premium rates  
10 that a health care insurer may charge an individual for health insurance  
11 coverage provided in the individual market.

12 2. Prevents a health care insurer that offers health insurance  
13 coverage in the individual market from establishing premium rates or  
14 modifying otherwise applicable copayments or deductibles in return for  
15 adherence to programs of health promotion and disease prevention.

16 3. Requires a health care insurer that offers only short-term limited  
17 duration insurance limited benefit coverage or to individuals and no other  
18 coverage to individuals in the individual market to offer individual health  
19 insurance coverage in the individual market.

20 4. Requires a health care insurer offering health care coverage only  
21 on a group basis or through one or more bona fide associations, or both, to  
22 offer health insurance coverage in the individual market.

23 J. A health care insurer shall provide, without charge, a written  
24 certificate of creditable coverage as described in this section for  
25 creditable coverage occurring after June 30, 1996 if the individual:

26 1. Ceases to be covered under a policy offered by a health care  
27 insurer. An individual who is covered by a policy that is issued on a group  
28 basis by a health care insurer, that is terminated or not renewed at the  
29 choice of the sponsor of the group and where the replacement of the coverage  
30 is without a break in coverage is not entitled to receive the certification  
31 prescribed in this paragraph but is instead entitled to receive the  
32 certification prescribed in paragraph 2 of this subsection.

33 2. Requests certification from the health care insurer within  
34 twenty-four months after the coverage under a health insurance coverage  
35 policy offered by a health care insurer ceases.

36 K. The certificate of creditable coverage provided by a health care  
37 insurer is a written certification of the period of creditable coverage of  
38 the individual under the health insurance coverage offered by the health care  
39 insurer. The department may enforce and monitor the issuance and delivery of  
40 the notices and certificates by health care insurers as required by this  
41 section, section 20-1380, the health insurance portability and accountability  
42 act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations  
43 adopted to implement the health insurance portability and accountability act  
44 of 1996.

1 L. Any health care insurer, accountable health plan or other entity  
2 that issues health care coverage in this state, as applicable, shall issue  
3 and accept a certificate of creditable coverage of the individual that  
4 contains at least the following information:

5 1. The date that the certificate is issued.

6 2. The name of the individual or dependent for whom the certificate  
7 applies and any other information that is necessary to allow the issuer  
8 providing the coverage specified in the certificate to identify the  
9 individual, including the individual's identification number under the policy  
10 and the name of the policyholder if the certificate is for or includes a  
11 dependent.

12 3. The name, address and telephone number of the issuer providing the  
13 certificate.

14 4. The telephone number to call for further information regarding the  
15 certificate.

16 5. One of the following:

17 (a) A statement that the individual has at least eighteen months of  
18 creditable coverage. For THE purposes of this subdivision, "eighteen months"  
19 means five hundred forty-six days.

20 (b) Both the date that the individual first sought coverage, as  
21 evidenced by a substantially complete application, and the date that  
22 creditable coverage began.

23 6. The date creditable coverage ended, unless the certificate  
24 indicates that creditable coverage is continuing from the date of the  
25 certificate.

26 7. The consumer assistance telephone number for the department.

27 8. The following statement in at least fourteen point type:

28 Important Notice!

29 Keep this certificate with your important personal records to  
30 protect your rights under the health insurance portability and  
31 accountability act of 1996 ("HIPAA"). This certificate is proof  
32 of your prior health insurance coverage. You may need to show  
33 this certificate to have a guaranteed right to buy new health  
34 insurance ("Guaranteed issue"). This certificate may also help  
35 you avoid waiting periods or exclusions for preexisting  
36 conditions. Under HIPAA, these rights are guaranteed only for a  
37 very short time period. After your group coverage ends, you  
38 must apply for new coverage within 63 days to be protected by  
39 HIPAA. If you have questions, call the Arizona department of  
40 insurance.

41 M. A health care insurer has satisfied the certification requirement  
42 under this section if the insurer offering the health benefits plan provides  
43 the certificate of creditable coverage in accordance with this section within  
44 thirty days after the event that triggered the issuance of the certificate.

1 N. Periods of creditable coverage for an individual are established by  
2 the presentation of the certificate described in this section and section  
3 20-2310. In addition to the written certificate of creditable coverage as  
4 described in this section, individuals may establish creditable coverage  
5 through the presentation of documents or other means. In order to make a  
6 determination that is based on the relevant facts and circumstances of the  
7 amount of creditable coverage that an individual has, a health care insurer  
8 shall take into account all information that the insurer obtains or that is  
9 presented to the insurer on behalf of the individual.

10 O. A health care insurer shall calculate creditable coverage according  
11 to the following rules:

12 1. The health care insurer shall allow an individual credit for each  
13 day the individual was covered by creditable coverage.

14 2. The health care insurer shall not count a period of creditable  
15 coverage for an individual enrolled under any form of health insurance  
16 coverage if after the period of coverage and before the enrollment date there  
17 were sixty-three consecutive days during which the individual was not covered  
18 by any creditable coverage.

19 3. The health care insurer shall not include any period that an  
20 individual is in a waiting period or an affiliation period for any health  
21 coverage or is awaiting action by a health care insurer on an application for  
22 the issuance of health insurance coverage when the health care insurer  
23 determines the continuous period pursuant to paragraph 1 of this subsection.

24 4. The health care insurer shall not include any period that an  
25 individual is waiting for approval of an application for health care  
26 coverage, provided the individual submitted an application to the health care  
27 insurer for health care coverage within sixty-three consecutive days after  
28 the individual's most recent creditable coverage.

29 5. The health care insurer shall not count a period of creditable  
30 coverage with respect to enrollment of an individual, if, after the most  
31 recent period of creditable coverage and before the enrollment date,  
32 sixty-three consecutive days lapse during all of which the individual was not  
33 covered under any creditable coverage. The health care insurer shall not  
34 include in the determination of the period of continuous coverage described  
35 in this section any period that an individual is in a waiting period for  
36 health insurance coverage offered by a health care insurer, is in a waiting  
37 period for benefits under a health benefits plan offered by an accountable  
38 health plan or is in an affiliation period.

39 6. In determining the extent to which an individual has satisfied any  
40 portion of any applicable preexisting condition period the health care  
41 insurer shall count a period of creditable coverage without regard to the  
42 specific benefits covered during that period.

43 P. An individual is an eligible individual if, on the date the  
44 individual seeks coverage pursuant to this section, the individual has an

- 1 aggregate period of creditable coverage as defined and calculated pursuant to  
2 this section of at least eighteen months and all of the following apply:
- 3 1. The most recent creditable coverage for the individual was under a  
4 plan offered by:
- 5 (a) An employee welfare benefit plan that provides medical care to  
6 employees or the employees' dependents directly or through insurance,  
7 reimbursement or otherwise pursuant to the employee retirement income  
8 security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code  
9 sections 1001 through 1461).
- 10 (b) A church plan as defined in the employee retirement income  
11 security act of 1974.
- 12 (c) A governmental plan as defined in the employee retirement income  
13 security act of 1974, including a plan established or maintained for its  
14 employees by the government of the United States or by any agency or  
15 instrumentality of the United States.
- 16 (d) An accountable health plan as defined in section 20-2301.
- 17 (e) A plan made available to a person defined as eligible pursuant to  
18 section 36-2901, paragraph 6, subdivision (d) or a dependent pursuant to  
19 section 36-2901, paragraph 6, subdivision (e) of a person eligible under  
20 section 36-2901, paragraph 6, subdivision (d), provided the person was most  
21 recently employed by a business in this state with at least two but not more  
22 than fifty full-time employees.
- 23 2. The individual is not eligible for coverage under:
- 24 (a) An employee welfare benefit plan that provides medical care to  
25 employees or the employees' dependents directly or through insurance,  
26 reimbursement or otherwise pursuant to the employee retirement income  
27 security act of 1974.
- 28 (b) A health benefits plan issued by an accountable health plan as  
29 defined in section 20-2301.
- 30 (c) Part A or part B of title XVIII of the social security act.
- 31 (d) Title 36, chapter 29, except coverage to persons defined as  
32 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and  
33 (e), or any other plan established under title XIX of the social security  
34 act, and the individual does not have other health insurance coverage.
- 35 3. The most recent coverage within the coverage period was not  
36 terminated based on any factor described in section 20-2309, subsection B,  
37 paragraph 1 or 2 relating to nonpayment of premiums or fraud.
- 38 4. The individual was offered and elected the option of continuation  
39 coverage under a COBRA continuation provision pursuant to the consolidated  
40 omnibus budget reconciliation act of 1985 (P.L. 99-272; 100 Stat. 82) or a  
41 similar state program.
- 42 5. The individual exhausted the continuation coverage pursuant to the  
43 consolidated omnibus budget reconciliation act of 1985.

1           Q. Notwithstanding subsection P of this section, an individual is an  
2 eligible individual if:

3           1. The individual is an individual enrollee in a health care services  
4 organization that is domiciled in this state on the date that the health care  
5 services organization is declared insolvent, including any health care  
6 services organization that is not an accountable health plan as defined in  
7 section 20-2301.

8           2. The individual's coverage terminates during the delinquency  
9 proceeding, after the health care services organization is declared  
10 insolvent.

11           3. The individual satisfies the requirements of an eligible individual  
12 as prescribed in this section other than the required period of creditable  
13 coverage.

14           R. Notwithstanding subsection P of this section, a newborn child,  
15 adopted child or child placed for adoption is an eligible individual if the  
16 child was timely enrolled and otherwise would have met the definition of an  
17 eligible individual as prescribed in this section other than the required  
18 period of creditable coverage and the child is not subject to any preexisting  
19 condition exclusion or limitation if the child has been continuously covered  
20 under health insurance coverage or a health benefits plan offered by an  
21 accountable health plan since birth, adoption or placement for adoption.

22           S. If a health care insurer imposes a waiting period for coverage of  
23 preexisting conditions, within a reasonable period of time after receiving an  
24 individual's proof of creditable coverage and not later than the date by  
25 which the individual must select an insurance plan, the health care insurer  
26 shall give the individual written disclosure of the insurer's determination  
27 regarding any preexisting condition exclusion period that applies to that  
28 individual. The disclosure shall include all of the following information:

29           1. The period of creditable coverage allowed toward the waiting period  
30 for coverage of preexisting conditions.

31           2. The basis for the insurer's determination and the source and  
32 substance of any information on which the insurer has relied.

33           3. A statement of any right the individual may have to present  
34 additional evidence of creditable coverage and to appeal the insurer's  
35 determination, including an explanation of any procedures for submission and  
36 appeal.

37           T. This section and section 20-1380 apply to all health insurance  
38 coverage that is offered, sold, issued, renewed, in effect or operated in the  
39 individual market after June 30, 1997, regardless of when a period of  
40 creditable coverage occurs.

41           U. For the purposes of this section and section 20-1380 as applicable:

42           1. "Affiliation period" has the same meaning prescribed in section  
43 20-2301.

1           2. "Bona fide association" means, for health care coverage issued by a  
2 health care insurer, an association that meets the requirements of section  
3 20-2324.

4           3. "Creditable coverage" means coverage solely for an individual,  
5 other than limited benefits coverage, under any of the following:

6           (a) An employee welfare benefit plan that provides medical care to  
7 employees or the employees' dependents directly or through insurance,  
8 reimbursement or otherwise pursuant to the employee retirement income  
9 security act of 1974.

10          (b) A church plan as defined in the employee retirement income  
11 security act of 1974.

12          (c) A health benefits plan issued by an accountable health plan as  
13 defined in section 20-2301.

14          (d) Part A or part B of title XVIII of the social security act.

15          (e) Title XIX of the social security act, other than coverage  
16 consisting solely of benefits under section 1928.

17          (f) Title 10, chapter 55 of the United States Code.

18          (g) A medical care program of the Indian health service or of a tribal  
19 organization.

20          (h) A health benefits risk pool operated by any state of the United  
21 States.

22          (i) A health plan offered pursuant to title 5, chapter 89 of the  
23 United States Code.

24          (j) A public health plan as defined by federal law.

25          (k) A health benefit plan pursuant to section 5(e) of the peace corps  
26 act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through  
27 2523).

28          (l) A policy or contract, including short-term limited duration  
29 insurance, issued on an individual basis by an insurer, a health care  
30 services organization, a hospital service corporation, a medical service  
31 corporation or a hospital, medical, dental and optometric service corporation  
32 or made available to persons defined as eligible under section 36-2901,  
33 paragraph 6, subdivision (b), (c), (d) or (e).

34          (m) A policy or contract issued by a health care insurer or an  
35 accountable health plan to a member of a bona fide association.

36          4. "Delinquency proceeding" has the same meaning prescribed in section  
37 20-611.

38          5. "Different policy forms" means variations between policy forms  
39 offered by a health care insurer, including policy forms that have different  
40 cost sharing arrangements or different riders.

41          6. "Genetic information" means information about genes, gene products  
42 and inherited characteristics that may derive from the individual or a family  
43 member, including information regarding carrier status and information  
44 derived from laboratory tests that identify mutations in specific genes or

1 chromosomes, physical medical examinations, family histories and direct  
2 analysis of genes or chromosomes.

3 7. "Health care insurer" means a disability insurer, group disability  
4 insurer, blanket disability insurer, health care services organization,  
5 hospital service corporation, medical service corporation or a hospital,  
6 medical, dental and optometric service corporation.

7 8. "Health status-related factor" means any factor in relation to the  
8 health of the individual or a dependent of the individual enrolled or to be  
9 enrolled in a health care services organization including:

10 (a) Health status.

11 (b) Medical condition, including physical and mental illness.

12 (c) Claims experience.

13 (d) Receipt of health care.

14 (e) Medical history.

15 (f) Genetic information.

16 (g) Evidence of insurability, including conditions arising out of acts  
17 of domestic violence as defined in section 20-448.

18 (h) The existence of a physical or mental disability.

19 9. "Higher level of coverage" means a policy form for which the  
20 actuarial value of the benefits under the health insurance coverage offered  
21 by a health care insurer is at least fifteen per cent more than the actuarial  
22 value of the health insurance coverage offered by the health care insurer as  
23 a lower level of coverage in this state but not more than one hundred twenty  
24 per cent of a policy form weighted average.

25 10. "Individual health insurance coverage" means health insurance  
26 coverage offered by a health care insurer to individuals in the individual  
27 market but does not include limited benefit coverage or short-term limited  
28 duration insurance. A health care insurer that offers limited benefit  
29 coverage or short-term limited duration insurance to individuals and no other  
30 coverage to individuals in the individual market is not a health care insurer  
31 that offers health insurance coverage in the individual market.

32 11. "Limited benefit coverage" has the same meaning prescribed in  
33 section 20-1137.

34 12. "Lower level of coverage" means a policy form offered by a health  
35 care insurer for which the actuarial value of the benefits under the health  
36 insurance coverage is at least eighty-five per cent but not more than one  
37 hundred per cent of the policy form weighted average.

38 13. "Network plan" means a health care plan provided by a health care  
39 insurer under which the financing and delivery of health care services are  
40 provided, in whole or in part, through a defined set of providers EITHER  
41 under contract with the A health care insurer LICENSED PURSUANT TO CHAPTER 4,  
42 ARTICLE 3 OF THIS TITLE OR UNDER CONTRACT WITH A HEALTH CARE INSURER in  
43 accordance with the determination made by the director pursuant to section

1 20-1053 regarding the geographic or service area in which a health care  
2 insurer may operate.

3 14. "Policy form weighted average" means the average actuarial value of  
4 the benefits provided by a health care insurer that issues health coverage in  
5 this state that is provided by either the health care insurer or, if the data  
6 are available, by all health care insurers that issue health coverage in this  
7 state in the individual health coverage market during the previous calendar  
8 year, except coverage pursuant to this section, weighted by the enrollment  
9 for all coverage forms.

10 15. "Preexisting condition" means a condition, regardless of the cause  
11 of the condition, for which medical advice, diagnosis, care, or treatment  
12 was recommended or received within not more than six months before the date  
13 of the enrollment of the individual under the health insurance policy or  
14 other contract that provides health coverage benefits. A genetic condition  
15 is not a preexisting condition in the absence of a diagnosis of the condition  
16 related to the genetic information and shall not result in a preexisting  
17 condition limitation or preexisting condition exclusion.

18 16. "Preexisting condition limitation" or "preexisting condition  
19 exclusion" means a limitation or exclusion of benefits for a preexisting  
20 condition under a health insurance policy or other contract that provides  
21 health coverage benefits.

22 17. "Short-term limited duration insurance" means health insurance  
23 coverage that is offered by a health care insurer, that remains in effect for  
24 no more than one hundred eighty-five days, that cannot be renewed or  
25 otherwise continued for more than one hundred eighty days and that is not  
26 intended or marketed as health insurance coverage subject to guaranteed  
27 issuance or guaranteed renewal provisions of the laws of this state but that  
28 is creditable coverage within the meaning of this section and section  
29 20-2301.

30 Sec. 5. Section 20-1402, Arizona Revised Statutes, is amended to read:

31 20-1402. Provisions of group disability policies; definitions

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

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

41 2. A provision that the insurer will furnish to the policyholder, for  
42 delivery to each employee or member of the insured group, an individual  
43 certificate setting forth in summary form a statement of the essential  
44 features of the insurance coverage of the employee or member and to whom

1 benefits are payable. If dependents or family members are included in the  
2 coverage additional certificates need not be issued for delivery to the  
3 dependents or family members. Any policy, except accidental death and  
4 dismemberment, applied for that provides family coverage shall, as to such  
5 coverage of family members, SHALL also provide that the benefits applicable  
6 for children shall be payable with respect to a newly born child of the  
7 insured from the instant of such child's birth, to a child adopted by the  
8 insured, regardless of the age at which the child was adopted, and to a child  
9 who has been placed for adoption with the insured and for whom the  
10 application and approval procedures for adoption pursuant to section 8-105 or  
11 8-108 have been completed to the same extent that such coverage applies to  
12 other members of the family. The coverage for newly born or adopted children  
13 or children placed for adoption shall include coverage of injury or sickness  
14 including the necessary care and treatment of medically diagnosed congenital  
15 defects and birth abnormalities. If payment of a specific premium is  
16 required to provide coverage for a child, the policy may require that  
17 notification of birth, adoption or adoption placement of the child and  
18 payment of the required premium must be furnished to the insurer within  
19 thirty-one days after the date of birth, adoption or adoption placement in  
20 order to have the coverage continue beyond such thirty-one day period.

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

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

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

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

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

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

38 5. A group disability insurance policy that provides coverage for the  
39 surgical expense of a mastectomy shall also provide coverage incidental to  
40 the patient's covered mastectomy for the expense of reconstructive surgery of  
41 the breast on which the mastectomy was performed, surgery and reconstruction  
42 of the other breast to produce a symmetrical appearance, prostheses,  
43 treatment of physical complications for all stages of the mastectomy,

1 including lymphedemas, and at least two external postoperative prostheses  
2 subject to all of the terms and conditions of the policy.

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

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

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

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

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

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

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

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

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

27 8. The coverage prescribed by paragraph 7 of this subsection is excess  
28 to any other coverage the natural mother may have for maternity benefits  
29 except coverage made available to persons pursuant to title 36, chapter 29,  
30 but not including coverage made available to persons defined as eligible  
31 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
32 such other coverage exists the agency, attorney or individual arranging the  
33 adoption shall make arrangements for the insurance to pay those costs that  
34 may be covered under that policy and shall advise the adopting parent in  
35 writing of the existence and extent of the coverage without disclosing any  
36 confidential information such as the identity of the natural parent. The  
37 insured adopting parents shall notify their insurer of the existence and  
38 extent of the other coverage.

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

1 subsection. The policy may provide that an attending provider in  
2 consultation with the mother may discharge the mother or the newborn child  
3 before the expiration of the minimum length of stay required by this  
4 subsection. The insurer shall not:

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

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

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

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

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

21 C. Nothing in subsection B of this section:

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

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

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

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

37 1. Blood glucose monitors.

38 2. Blood glucose monitors for the legally blind.

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

41 4. Insulin preparations and glucagon.

42 5. Insulin cartridges.

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

44 7. Injection aids.

- 1           8. Insulin cartridges for the legally blind.
- 2           9. Syringes and lancets including automatic lancing devices.
- 3           10. Prescribed oral agents for controlling blood sugar that are
- 4 included on the plan formulary.
- 5           11. To the extent coverage is required under medicare, podiatric
- 6 appliances for prevention of complications associated with diabetes.
- 7           12. Any other device, medication, equipment or supply for which
- 8 coverage is required under medicare from and after January 1, 1999. The
- 9 coverage required in this paragraph is effective six months after the
- 10 coverage is required under medicare.
- 11           E. Nothing in subsection D of this section prohibits a group
- 12 disability insurer from imposing deductibles, coinsurance or other cost
- 13 sharing in relation to benefits for equipment or supplies for the treatment
- 14 of diabetes.
- 15           F. Any contract that provides coverage for prescription drugs shall
- 16 not limit or exclude coverage for any prescription drug prescribed for the
- 17 treatment of cancer on the basis that the prescription drug has not been
- 18 approved by the United States food and drug administration for the treatment
- 19 of the specific type of cancer for which the prescription drug has been
- 20 prescribed, if the prescription drug has been recognized as safe and
- 21 effective for treatment of that specific type of cancer in one or more of the
- 22 standard medical reference compendia prescribed in subsection G of this
- 23 section or medical literature that meets the criteria prescribed in
- 24 subsection G of this section. The coverage required under this subsection
- 25 includes covered medically necessary services associated with the
- 26 administration of the prescription drug. This subsection does not:
- 27           1. Require coverage of any prescription drug used in the treatment of
- 28 a type of cancer if the United States food and drug administration has
- 29 determined that the prescription drug is contraindicated for that type of
- 30 cancer.
- 31           2. Require coverage for any experimental prescription drug that is not
- 32 approved for any indication by the United States food and drug
- 33 administration.
- 34           3. Alter any law with regard to provisions that limit the coverage of
- 35 prescription drugs that have not been approved by the United States food and
- 36 drug administration.
- 37           4. Require reimbursement or coverage for any prescription drug that is
- 38 not included in the drug formulary or list of covered prescription drugs
- 39 specified in the contract.
- 40           5. Prohibit a contract from limiting or excluding coverage of a
- 41 prescription drug, if the decision to limit or exclude coverage of the
- 42 prescription drug is not based primarily on the coverage of prescription
- 43 drugs required by this section.

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

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

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

7           ~~(a) The American medical association drug evaluations, a publication~~  
8 ~~of the American medical association.~~

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

11           ~~(c) Drug information for the health care provider, a publication of~~  
12 ~~the United States pharmacopoeia convention.~~

13           (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
14 COMPENDIUM.

15           (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

16           (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

17           (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
18 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

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

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

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

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

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

40           1. Be part of the newborn screening program prescribed in section  
41 36-694.

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

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

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

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

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

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

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

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

38          M. Notwithstanding subsection L of this section, a religious employer  
39 whose religious tenets prohibit the use of prescribed contraceptive methods  
40 may require that the insurer provide a group disability policy without  
41 coverage for all United States food and drug administration approved  
42 contraceptive methods. A religious employer shall submit a written affidavit  
43 to the insurer stating that it is a religious employer. On receipt of the  
44 affidavit, the insurer shall issue to the religious employer a group

1 disability policy that excludes coverage of prescription contraceptive  
2 methods. The insurer shall retain the affidavit for the duration of the  
3 group disability policy and any renewals of the policy. Before a policy is  
4 issued, every religious employer that invokes this exemption shall provide  
5 prospective insureds written notice that the religious employer refuses to  
6 cover all United States food and drug administration approved contraceptive  
7 methods for religious reasons. This subsection shall not exclude coverage  
8 for prescription contraceptive methods ordered by a health care provider with  
9 prescriptive authority for medical indications other than to prevent an  
10 unintended pregnancy. An insurer may require the insured to first pay for  
11 the prescription and then submit a claim to the insurer along with evidence  
12 that the prescription is for a noncontraceptive purpose. An insurer may  
13 charge an administrative fee for handling these claims. A religious employer  
14 shall not discriminate against an employee who independently chooses to  
15 obtain insurance coverage or prescriptions for contraceptives from another  
16 source.

17 N. For the purposes of:

18 1. This section:

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

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

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

25 (i) Formulated to be consumed or administered enterally under the  
26 supervision of a physician who is licensed pursuant to title 32, chapter 13  
27 or 17 or a registered nurse practitioner who is licensed pursuant to title  
28 32, chapter 15.

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

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

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

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

39 (i) Formulated to be consumed or administered enterally under the  
40 supervision of a physician who is licensed pursuant to title 32, chapter 13  
41 or 17 or a registered nurse practitioner who is licensed pursuant to title  
42 32, chapter 15.

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

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

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

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

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

16 (a) The entity primarily employs persons who share the religious  
17 tenets of the entity.

18 (b) The entity serves primarily persons who share the religious tenets  
19 of the entity.

20 (c) The entity is a nonprofit organization as described in section  
21 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

22 Sec. 6. Section 20-1404, Arizona Revised Statutes, is amended to read:  
23 20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

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

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

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

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

24          E. Any policy or contract, except accidental death and dismemberment,  
25 applied for that provides family coverage ~~shall~~, as to such coverage of  
26 family members, SHALL also provide that the benefits applicable for children  
27 shall be payable with respect to a newly born child of the insured from the  
28 instant of such child's birth, to a child adopted by the insured, regardless  
29 of the age at which the child was adopted, and to a child who has been placed  
30 for adoption with the insured and for whom the application and approval  
31 procedures for adoption pursuant to section 8-105 or 8-108 have been  
32 completed to the same extent that such coverage applies to other members of  
33 the family. The coverage for newly born or adopted children or children  
34 placed for adoption shall include coverage of injury or sickness including  
35 necessary care and treatment of medically diagnosed congenital defects and  
36 birth abnormalities. If payment of a specific premium is required to provide  
37 coverage for a child, the policy or contract may require that notification of  
38 birth, adoption or adoption placement of the child and payment of the  
39 required premium must be furnished to the insurer within thirty-one days  
40 after the date of birth, adoption or adoption placement in order to have the  
41 coverage continue beyond the thirty-one day period.

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

- 1           1. For performance of any surgical service that is covered by the  
2 terms of such contract, regardless of the place of service.
- 3           2. For any home health services that are performed by a licensed home  
4 health agency and that a physician has prescribed in lieu of hospital  
5 services, as defined by the director, providing the hospital services would  
6 have been covered.
- 7           3. For any diagnostic service that a physician has performed outside a  
8 hospital in lieu of inpatient service, providing the inpatient service would  
9 have been covered.
- 10          4. For any service performed in a hospital's outpatient department or  
11 in a freestanding surgical facility, providing such service would have been  
12 covered if performed as an inpatient service.
- 13          G. A blanket disability insurance policy that provides coverage for  
14 the surgical expense of a mastectomy shall also provide coverage incidental  
15 to the patient's covered mastectomy for the expense of reconstructive surgery  
16 of the breast on which the mastectomy was performed, surgery and  
17 reconstruction of the other breast to produce a symmetrical appearance,  
18 prostheses, treatment of physical complications for all stages of the  
19 mastectomy, including lymphedemas, and at least two external postoperative  
20 prostheses subject to all of the terms and conditions of the policy.
- 21          H. A contract that provides coverage for surgical services for a  
22 mastectomy shall also provide coverage for mammography screening performed on  
23 dedicated equipment for diagnostic purposes on referral by a patient's  
24 physician, subject to all of the terms and conditions of the policy and  
25 according to the following guidelines:
  - 26           1. A baseline mammogram for a woman from age thirty-five to  
27 thirty-nine.
  - 28           2. A mammogram for a woman from age forty to forty-nine every two  
29 years or more frequently based on the recommendation of the woman's  
30 physician.
  - 31           3. A mammogram every year for a woman fifty years of age and over.
- 32          I. Any contract that is issued to the insured and that provides  
33 coverage for maternity benefits shall also provide that the maternity  
34 benefits apply to the costs of the birth of any child legally adopted by the  
35 insured if all the following are true:
  - 36           1. The child is adopted within one year of birth.
  - 37           2. The insured is legally obligated to pay the costs of birth.
  - 38           3. All preexisting conditions and other limitations have been met by  
39 the insured.
  - 40           4. The insured has notified the insurer of his acceptability to adopt  
41 children pursuant to section 8-105, within sixty days after such approval or  
42 within sixty days after a change in insurance policies, plans or companies.
- 43          J. The coverage prescribed by subsection I of this section is excess  
44 to any other coverage the natural mother may have for maternity benefits

1 except coverage made available to persons pursuant to title 36, chapter 29,  
2 but not including coverage made available to persons defined as eligible  
3 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If  
4 such other coverage exists the agency, attorney or individual arranging the  
5 adoption shall make arrangements for the insurance to pay those costs that  
6 may be covered under that policy and shall advise the adopting parent in  
7 writing of the existence and extent of the coverage without disclosing any  
8 confidential information such as the identity of the natural parent. The  
9 insured adopting parents shall notify their insurer of the existence and  
10 extent of the other coverage.

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

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

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

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

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

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

37 L. Nothing in subsection K of this section:

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

40 2. Prevents an insurer from imposing deductibles, coinsurance or other  
41 cost sharing in relation to benefits for hospital lengths of stay in  
42 connection with childbirth for a mother or a newborn child under the  
43 contract, except that any coinsurance or other cost sharing for any portion  
44 of a period within a hospital length of stay required pursuant to subsection

1 K of this section shall not be greater than the coinsurance or cost sharing  
2 for any preceding portion of that stay.

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

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

9 1. Blood glucose monitors.

10 2. Blood glucose monitors for the legally blind.

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

13 4. Insulin preparations and glucagon.

14 5. Insulin cartridges.

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

16 7. Injection aids.

17 8. Insulin cartridges for the legally blind.

18 9. Syringes and lancets including automatic lancing devices.

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

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

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

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

31 O. 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 P of this  
39 section or medical literature that meets the criteria prescribed in  
40 subsection P 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 P. For the purposes of subsection O 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)~~ (a) 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 (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
29 COMPENDIUM.

30 (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

31 (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

32 (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
33 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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.

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

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

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

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

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

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

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

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

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

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

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

1 the deductibles, coinsurance, copayments or other cost containment measures  
2 for 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 V. Notwithstanding subsection U 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 blanket disability policy without  
12 coverage for all 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 blanket  
16 disability policy that excludes coverage of prescription contraceptive  
17 methods. The insurer shall retain the affidavit for the duration of the  
18 blanket 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 United States food and drug administration approved contraceptive  
22 methods for religious reasons. This subsection shall not exclude coverage  
23 for prescription contraceptive methods ordered by a health care provider with  
24 prescriptive authority for medical indications other than to prevent an  
25 unintended pregnancy. An insurer may require the insured to first pay for  
26 the prescription and then submit a claim to the insurer along with evidence  
27 that the prescription is for a noncontraceptive purpose. An insurer may  
28 charge an administrative fee for handling these claims under this subsection.  
29 A 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 W. 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 or a registered nurse practitioner who is licensed pursuant to title  
43 32, chapter 15.

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

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

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

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

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

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

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

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

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

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

30 (a) The entity primarily employs persons who share the religious  
31 tenets of the entity.

32 (b) The entity serves primarily persons who share the religious tenets  
33 of the entity.

34 (c) The entity is a nonprofit organization as described in section  
35 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

36 Sec. 7. Section 20-2326, Arizona Revised Statutes, is amended to read:  
37 20-2326. Drugs; cancer treatment; definitions

38 A. Any health benefits plan that is offered by an accountable health  
39 plan and that provides coverage for prescription drugs shall not limit or  
40 exclude coverage for any prescription drug prescribed for the treatment of  
41 cancer on the basis that the prescription drug has not been approved by the  
42 United States food and drug administration for the treatment of the specific  
43 type of cancer for which the prescription drug has been prescribed, if the  
44 prescription drug has been recognized as safe and effective for treatment of

1 that specific type of cancer in one or more of the standard medical reference  
2 compendia prescribed in subsection B or medical literature that meets the  
3 criteria prescribed in subsection B. The coverage required under this  
4 subsection includes covered medically necessary services associated with the  
5 administration of the prescription drug. This subsection does not:

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

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

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

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

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

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

26 B. For the purposes of subsection A:

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

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

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

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

35 (b) THE NATIONAL COMPREHENSIVE CANCER NETWORK DRUGS AND BIOLOGICS  
36 COMPENDIUM.

37 (c) THOMSON MICROMEDEX COMPENDIUM DRUGDEX.

38 (d) ELSEVIER GOLD STANDARD'S CLINICAL PHARMACOLOGY COMPENDIUM.

39 (e) OTHER AUTHORITATIVE COMPENDIA AS IDENTIFIED BY THE SECRETARY OF  
40 THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

42 (a) At least two articles from major peer reviewed professional  
43 medical journals have recognized, based on scientific or medical criteria,

1 the drug's safety and effectiveness for treatment of the indication for which  
2 the drug has been prescribed.

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

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

APPROVED BY THE GOVERNOR JULY 10, 2009.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JULY 10, 2009.

Passed the House \_\_\_\_\_, 20 \_\_\_\_\_,

by the following vote: \_\_\_\_\_ Ayes,

\_\_\_\_\_ Nays, \_\_\_\_\_ Not Voting

\_\_\_\_\_  
Speaker of the House

\_\_\_\_\_  
Chief Clerk of the House

Passed the Senate June 25, 20 09,

by the following vote: 26 Ayes,

1 Nays, 3 Not Voting

Robert L. Berry  
President of the Senate

Chaimin Bellington  
Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF GOVERNOR

This Bill was received by the Governor this

\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_,

at \_\_\_\_\_ o'clock \_\_\_\_\_ M.

\_\_\_\_\_  
Secretary to the Governor

Approved this \_\_\_\_\_ day of

\_\_\_\_\_, 20 \_\_\_\_\_,

\_\_\_\_\_ o'clock \_\_\_\_\_ M.

\_\_\_\_\_  
Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_,

at \_\_\_\_\_ o'clock \_\_\_\_\_ M.

\_\_\_\_\_  
Secretary of State

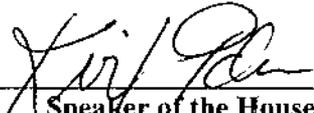
**H.B. 2145**

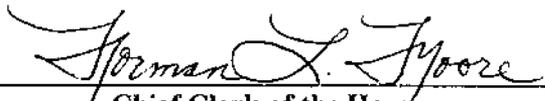
HOUSE CONCURS IN SENATE  
AMENDMENTS AND FINAL PASSAGE

Passed the House June 29, 2009

by the following vote: 53 Ayes,

0 Nays, 7 Not Voting

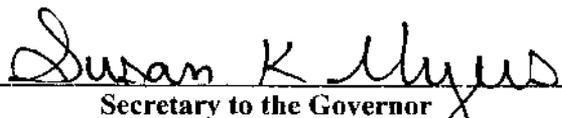
  
Speaker of the House

  
Chief Clerk of the House

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF GOVERNOR

This Bill received by the Governor this  
15<sup>th</sup> day of July, 2009

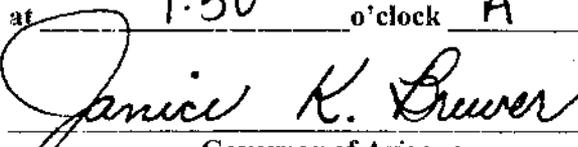
at 8:25 o'clock A. M.

  
Secretary to the Governor

Approved this 10<sup>th</sup> day of

July 2009

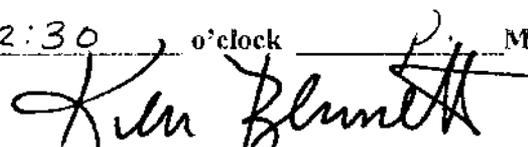
at 9:50 o'clock A. M.

  
Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF SECRETARY OF STATE

This Bill received by the Secretary of State  
this 10 day of July, 2009

at 12:30 o'clock P. M.

  
Secretary of State