REFERENCE TITLE: preexisting condition exclusions; prohibition

State of Arizona
House of Representatives
Forty-ninth Legislature
Second Regular Session
2010

# HB 2291

Introduced by
Representatives McGuire, Heinz, Pancrazi, Sinema, Young Wright, Senator Rios: Representatives Brown, Campbell CH, Campbell CL, Deschene, Garcia M, Tovar

AN ACT

AMENDING SECTION 20-826, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-826.05; AMENDING SECTIONS 20-841.06, 20-1057, 20-1057.03 AND 20-1057.04; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.12, ARIZONA REVISED STATUTES; AMENDING SECTION 20-1342, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1342.06; AMENDING SECTIONS 20-1377, 20-1379 AND 20-1402, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1402.04; AMENDING SECTION 20-1404, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1404.04; AMENDING SECTIONS 20-1408, 20-2301, 20-2304, 20-2308, 20-2310 AND 20-2321, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE COVERAGE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Conditions of eligibility.

2. Coverage of dependents.

~~3. Preexisting conditions.~~

~~4.~~ 3. Termination of insurance.

~~5.~~ 4. Probationary periods.

~~6.~~ 5. Limitations.

~~7.~~ 6. Exceptions.

~~8.~~ 7. Reductions.

~~9.~~ 8. Elimination periods.

~~10.~~ 9. Requirements for replacement.

~~11.~~ 10. Any other condition of subscription contracts.

N. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a

normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the corporation for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The corporation shall not:

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

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

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

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

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

O. Nothing in subsection N of this section:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.
5. Insulin cartridges.
6. Drawing up devices and monitors for the visually impaired.
7. Injection aids.
8. Insulin cartridges for the legally blind.
9. Syringes and lancets including automatic lancing devices.
10. Prescribed oral agents for controlling blood sugar that are included on the plan formulary.
11. To the extent coverage is required under medicare, podiatric appliances for prevention of complications associated with diabetes.
12. Any other device, medication, equipment or supply for which coverage is required under medicare from and after January 1, 1999. The coverage required in this paragraph is effective six months after the coverage is required under medicare.

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

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

1. Require coverage of any prescription drug used in the treatment of a type of cancer if the United States food and drug administration has determined that the prescription drug is contraindicated for that type of cancer.
2. Require coverage for any experimental prescription drug that is not approved for any indication by the United States food and drug administration.
3. Alter any law with regard to provisions that limit the coverage of prescription drugs that have not been approved by the United States food and drug administration.
4. Notwithstanding section 20-841.05, require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the contract.

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

T. A corporation shall not issue or deliver any advertising matter or sales material to any person in this state until the corporation files the advertising matter or sales material with the director. This subsection does not require a corporation to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the corporation to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

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

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

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

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

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

AA. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. Title 20, chapter 4, article 3, Arizona Revised Statutes, is amended by adding section 20-826.05, to read:

20-826.05. Subscription contracts; preexisting condition limitations or exclusions; prohibition; definitions

A. A CONTRACT ISSUED BY A HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL AND MEDICAL SERVICE CORPORATION SHALL NOT IMPOSE ANY PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY PREEXISTING CONDITION.

B. FOR THE PURPOSES OF THIS SECTION:

1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING CONDITION EXCLUSION.

2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS.

Sec. 3. Section 20-841.06, Arizona Revised Statutes, is amended to read:

20-841.06. Continuity of care; definition

A. Any corporation that offers a health benefits plan shall allow any new subscriber whose health care provider is not a member of the provider network, on written request of the subscriber to the corporation, to continue an active course of treatment with that health care provider during a transitional period after the effective date of the enrollment if both of the following apply:

1. The subscriber has either:

(a) A life threatening disease or condition, in which case the transitional period is not more than thirty days after the effective date of the enrollment.

(b) ~~Entered~~ IS IN the third trimester of pregnancy on the effective date of the enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

2. The subscriber's health care provider agrees in writing to do all of the following:

(a) Except for copayment, coinsurance or deductible amounts, accept as payment in full reimbursement from the corporation at the rates that are established by the corporation and that are not more than the level of

reimbursement applicable to similar services by health care providers within the provider network.

(b) Comply with the corporation's quality assurance and utilization review requirements and provide to the corporation any necessary medical information related to the care.

(c) Comply with the corporation's policies and procedures pursuant to this article including procedures relating to referrals and obtaining preauthorization, claims handling and treatment plan approval by the corporation.

B. A corporation shall allow any subscriber whose health care provider is terminated from the provider network by the corporation except for reasons of medical incompetence or unprofessional conduct, on written request of the subscriber to the corporation, to continue an active course of treatment with that health care provider during a transitional period after the date of the provider's disaffiliation from the provider network, if both of the following apply:

1. The subscriber has either:

(a) A life threatening disease or condition, in which case the transitional period is not more than thirty days after the date of the provider's disaffiliation from the provider network.

(b) ~~Entered~~ IS IN the third trimester of pregnancy on the date of the provider's disaffiliation, in which case the transition period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

2. The subscriber's health care provider agrees in writing to do all of the following:

(a) Except for copayment, coinsurance or deductible amounts, continue to accept as payment in full reimbursement from the corporation at the rates applicable before the beginning of the transitional period.

(b) Comply with the corporation's quality assurance and utilization review requirements and provide to the corporation any necessary medical information related to the care.

(c) Comply with the corporation's policies and procedures pursuant to this article including procedures relating to referrals and obtaining preauthorization, claims handling and treatment plan approval by the corporation.

C. This section does not require a corporation to provide coverage for benefits that are not covered by the subscriber's contract. ~~and does not diminish or impair any preexisting condition limitation in the contract.~~

D. This section does not extend to a health care provider who is not a member of the provider network any contractual rights or remedies beyond those rights or remedies related to and necessary for the provision of covered services to the specific subscriber during the required transitional period.

E. This section does not apply to any corporation that holds a certificate of authority to operate either as a dental service corporation or an optometric service corporation.

F. For the purposes of this section, "health care provider" means any physician who is licensed in this state pursuant to title 32, chapter 13 or 17.

Sec. 4. Section 20-1057, Arizona Revised Statutes, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the natural mother and child had received the maternity and newborn care directly from or through that health care services organization.

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

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

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

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

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

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

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

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

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

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

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

coverage upon release from active military duty subject to the following conditions:

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

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

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

1. Conditions of eligibility.

2. Coverage of dependents.

~~3. Preexisting conditions.~~

~~4.~~ 3. Termination of insurance.

~~5.~~ 4. Probationary periods.

~~6.~~ 5. Limitations.

~~7.~~ 6. Exceptions.

~~8.~~ 7. Reductions.

~~9.~~ 8. Elimination periods.

~~10.~~ 9. Requirements for replacement.

~~11.~~ 10. Any other conditions of evidences of coverage.

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

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

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

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

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

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

S. Nothing in subsection R of this section:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

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

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

U. Nothing in subsection T of this section:

1. Entitles a member or enrollee of a health care services organization to equipment or supplies for the treatment of diabetes that are

not medically necessary as determined by the health care services organization medical director or the medical director's designee.

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

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

DD. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. Section 20-1057.03, Arizona Revised Statutes, is amended to read:

20-1057.03. Chiropractic care; definitions

A. Every health care services organization shall provide coverage for chiropractic services provided by network chiropractic providers pursuant to this section.

B. A health care services organization is not required to provide coverage for chiropractic services obtained from a provider who is not a member of the health care services organization's provider network.

C. An enrollee may obtain medically necessary chiropractic services from a network chiropractic provider through self-referral for a minimum of twelve visits in an annual contract period, unless the enrollee's evidence of coverage with the health care services organization allows for additional visits or benefits.

D. This section does not:

1. Require a health care services organization to provide services that are not covered by the enrollee's evidence of coverage. ~~and does not diminish or impair any preexisting condition limitation in the evidence of coverage.~~

2. Prohibit an enrollee from seeking chiropractic services in addition to the limits prescribed in this section from any chiropractic provider if the enrollee accepts financial responsibility for those services.

E. Nothing in this section prohibits the use of deductibles, coinsurance, copayments or other cost sharing in relation to the chiropractic benefits offered.

F. For the purposes of this section:

1. "Chiropractic services" means only nonsurgical and noninvasive treatment of neck and back pain through physiotherapy, musculoskeletal manipulation and other physical corrections of musculoskeletal conditions within the scope of the chiropractic practice.

2. "Musculoskeletal" means any function of the musculoskeletal system that is integrated with neurological function and is expressed by biological regulatory mechanisms.

3. "Network chiropractic provider" means a chiropractic physician who is licensed pursuant to title 32, chapter 8 and who is under written contract with the health care services organization to provide services pursuant to this section.

4. "Self-referral" means obtaining treatment by a provider without referral from a primary care physician.

Sec. 6. Section 20-1057.04, Arizona Revised Statutes, is amended to read:

20-1057.04. Continuity of care; definition

A. A health care services organization shall allow any new enrollee whose health care provider is not a member of the provider network, on written request of the enrollee to the health care services organization, to continue an active course of treatment with that health care provider during a transitional period after the effective date of the enrollment if both of the following apply:

1. The enrollee has either:

(a) A life threatening disease or condition, in which case the transitional period is not more than thirty days after the effective date of the enrollment.

(b) ~~Entered~~ IS IN the third trimester of pregnancy on the effective date of the enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

2. The enrollee's health care provider agrees in writing to do all of the following:

(a) Except for copayment, coinsurance or deductible amounts, accept as payment in full reimbursement from the health care services organization at the rates that are established by the health care services organization and that are not more than the level of reimbursement applicable to similar services by health care providers within the provider network.

(b) Comply with the health care services organization's quality assurance and utilization review requirements and provide to the health care services organization any necessary medical information related to the care.

(c) Comply with the health care services organization's policies and procedures pursuant to this article including procedures relating to referrals and obtaining preauthorization, claims handling and treatment plan approval by the health care services organization.

B. A health care services organization shall allow any enrollee whose health care provider is terminated from the provider network by the health care services organization except for reasons of medical incompetence or unprofessional conduct, on written request of the enrollee to the health care services organization, to continue an active course of treatment with that health care provider during a transitional period after the date of the provider's disaffiliation from the provider network, if both of the following apply:

1. The enrollee has either:

(a) A life threatening disease or condition, in which case the transitional period is not more than thirty days after the date of the provider's disaffiliation from the provider network.

(b) ~~Entered~~ IS IN the third trimester of pregnancy on the date of the provider's disaffiliation, in which case the transition period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

2. The enrollee's health care provider agrees in writing to do all of the following:

(a) Except for copayment, coinsurance or deductible amounts, continue to accept as payment in full reimbursement from the health care services organization at the rates applicable before the beginning of the transitional period.

(b) Comply with the health care services organization's quality assurance and utilization review requirements and provide to the health care services organization any necessary medical information related to the care.

(c) Comply with the health care services organization's policies and procedures pursuant to this article including procedures relating to

referrals and obtaining preauthorization, claims handling and treatment plan approval by the health care services organization.

C. This section does not require a health care services organization to provide coverage for benefits that are not covered by the enrollee's evidence of coverage. ~~and does not diminish or impair any preexisting condition limitation in the evidence of coverage.~~

D. This section does not extend to a health care provider who is not a member of the provider network any contractual rights or remedies beyond those rights or remedies related to and necessary for the provision of covered services to the specific enrollee during the required transitional period.

E. For the purposes of this section, "health care provider" means any physician who is licensed in this state pursuant to title 32, chapter 13 or 17.

Sec. 7. Title 20, chapter 4, article 9, Arizona Revised Statutes, is amended by adding section 20-1057.12, to read:

20-1057.12. Evidence of coverage; preexisting condition limitations or exclusions; prohibition; definitions

A. A CONTRACT OR EVIDENCE OF COVERAGE ISSUED BY A HEALTH CARE SERVICES ORGANIZATION SHALL NOT IMPOSE ANY PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY PREEXISTING CONDITION.

B. FOR THE PURPOSES OF THIS SECTION:

1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING CONDITION EXCLUSION.

2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS.

Sec. 8. Section 20-1342, Arizona Revised Statutes, is amended to read:

20-1342. Scope and format of policy; definitions

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

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

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

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

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

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

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

7. The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except

in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the director.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Nothing in subsection B of this section:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

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

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

E. Nothing in subsection D of this section:

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

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

F. Any contract that provides coverage for prescription drugs shall not limit or exclude coverage for any prescription drug prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the United States food and drug administration for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia prescribed in subsection G of this

section or medical literature that meets the criteria prescribed in subsection G of this section. The coverage required under this subsection includes covered medically necessary services associated with the administration of the prescription drug. This subsection does not:

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

L. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. Title 20, chapter 6, article 4, Arizona Revised Statutes, is amended by adding section 20-1342.06, to read:

20-1342.06. Disability insurance policies; preexisting condition limitations or exclusions; prohibition; definitions

A. A POLICY ISSUED BY A DISABILITY INSURER SHALL NOT IMPOSE ANY PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY PREEXISTING CONDITION.

B. FOR THE PURPOSES OF THIS SECTION:

1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH

COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING CONDITION EXCLUSION.

2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS.

Sec. 10. Section 20-1377, Arizona Revised Statutes, is amended to read:

20-1377. Continuation of coverage under individual policies; requirements; exceptions; renewability

A. A policy of disability insurance delivered or issued for delivery in this state shall provide for the right of covered family members to continue coverage on the death of the named insured, the entry of a decree of dissolution of marriage of the named insured and any other conditions, other than failure of the insured to pay the required premium, specifically stated in the policy under which coverage would otherwise terminate as to the covered spouse or covered dependent children of the named insured.

B. At the option of the insurer, coverage shall either continue under the existing policy or by the issuance of a converted policy with the person exercising the right to convert designated as the named insured. Coverage provided by a conversion policy must provide benefits most similar to the coverage contained in the policy that was terminated. A person entitled to continuation or conversion rights under this section may elect a lesser form of coverage.

C. Continuation or conversion of coverage ~~may~~, at the option of the spouse exercising the right, MAY include covered dependent children for whom the spouse has responsibility for care or support.

D. The person exercising the continuation or conversion rights shall notify the insurer and make payment of the appropriate premium within thirty-one days following the termination of the existing policy. A monthly premium rate shall be offered to the person exercising continuation or conversion rights, and payment of one monthly premium shall be deemed sufficient consideration to enact the continuation or conversion policy.

E. Coverage provided through continuation or conversion shall be without additional evidence of insurability and shall not impose any preexisting condition limitations, exclusions or other contractual time limitations other than those remaining unexpired under the policy or contract from which continuation or conversion is exercised.

F. Conversion is not available to a person who is eligible for medicare or eligible for or covered by other similar disability benefits which together with the conversion coverage would constitute overinsurance.

G. This section does not apply to disability income policies, to accidental death or dismemberment policies or to single term nonrenewable policies.

H. Each policy of disability insurance shall include notice of the continuation and conversion privilege.

I. Except as provided in subsection J of this section, any policy, including a conversion or continuation policy, that is issued under this section shall not be cancelled or nonrenewed except for the following reasons:

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

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

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

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

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

J. An insurer who offers only one form of an individual medical expense policy may modify the conversion policy if the modification complies with the notice and disclosure requirements set forth in the policy and applies uniformly to the policy offered to the general public and to the conversion policy.

K. At the time of filing a petition for dissolution of marriage, the clerk of the court shall provide to the petitioner for a dissolution of marriage two copies of the notice of the right of a dependent spouse to convert health insurance coverage under this section. The petitioner shall cause one copy of the notice to be served on the respondent together with a copy of the petition, summons and preliminary injunction. The director shall prepare the notice which must include a summary of this section. The clerk of the court or the director is not liable for damages arising from information contained in or omitted from the notices prepared or provided under this ~~section~~ SUBSECTION.

L. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who had

coverage under an individual disability insurance policy at such time shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

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

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

M. Each dependent of a person eligible for reinstatement under SUBSECTION L OF this section shall be afforded the same rights and be subject to the same conditions as the insured, if the dependent was insured under the individual disability insurance policy at the time the eligible person entered active duty. Any dependent of such person born during the period of active military duty shall have the same rights as other dependents noted in this ~~section~~ SUBSECTION.

N. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with the provisions of subsection L of this section, including:

1. Conditions of eligibility.

2. Coverage of dependents.

~~3. Preexisting conditions.~~

~~4.~~ 3. Termination of insurance.

~~5.~~ 4. Probationary periods.

~~6.~~ 5. Limitations.

~~7.~~ 6. Exceptions.

~~8.~~ 7. Reductions.

~~9.~~ 8. Elimination periods.

~~10.~~ 9. Requirements for replacement.

~~11.~~ 10. Any other conditions of coverage.

Sec. 11. Section 20-1379, Arizona Revised Statutes, is amended to read:

20-1379. Guaranteed availability of individual health insurance coverage; prior group coverage; definitions

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

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

2. Impose any preexisting condition exclusion for that coverage.

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

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

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

2. The offer includes at least either:

(a) The policy forms with the largest and next to the largest earned premium volume of all policy forms offered by the health care insurer in this state in the individual market during a period not to exceed the preceding two calendar years.

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

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

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

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

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

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

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

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

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

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

G. If a health care insurer denies health insurance coverage in this state pursuant to subsection F of this section, the health care insurer shall not offer that coverage in the individual market in this state for one hundred eighty days after the date the coverage is denied or until the health care insurer demonstrates to the director that the health care insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

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

I. Nothing in this section:

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

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

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

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

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

1. Ceases to be covered under a policy offered by a health care insurer. An individual who is covered by a policy that is issued on a group

basis by a health care insurer, that is terminated or not renewed at the choice of the sponsor of the group and where the replacement of the coverage is without a break in coverage is not entitled to receive the certification prescribed in this paragraph but is instead entitled to receive the certification prescribed in paragraph 2 of this subsection.

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

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

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

1. The date that the certificate is issued.

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

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

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

5. One of the following:

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

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

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

7. The consumer assistance telephone number for the department.

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

Important Notice!

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

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

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

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

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

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

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

4. The health care insurer shall not include any period that an individual is waiting for approval of an application for health care coverage, provided the individual submitted an application to the health care

insurer for health care coverage within sixty-three consecutive days after the individual's most recent creditable coverage.

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

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

P. An individual is an eligible individual if, on the date the individual seeks coverage pursuant to this section, the individual has an aggregate period of creditable coverage as defined and calculated pursuant to this section of at least eighteen months and all of the following apply:

1. The most recent creditable coverage for the individual was under a plan offered by:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code sections 1001 through 1461).

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

(c) A governmental plan as defined in the employee retirement income security act of 1974, including a plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the United States.

(d) An accountable health plan as defined in section 20-2301.

(e) A plan made available to a person defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (d) or a dependent pursuant to section 36-2901, paragraph 6, subdivision (e) of a person eligible under section 36-2901, paragraph 6, subdivision (d), provided the person was most recently employed by a business in this state with at least two but not more than fifty full-time employees.

2. The individual is not eligible for coverage under:

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

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

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

(d) Title 36, chapter 29, except coverage to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), or any other plan established under title XIX of the social security act, and the individual does not have other health insurance coverage.

3. The most recent coverage within the coverage period was not terminated based on any factor described in section 20-2309, subsection B, paragraph 1 or 2 relating to nonpayment of premiums or fraud.

4. The individual was offered and elected the option of continuation coverage under a COBRA continuation provision pursuant to the consolidated omnibus budget reconciliation act of 1985 (P.L. 99-272; 100 Stat. 82) or a similar state program.

5. The individual exhausted the continuation coverage pursuant to the consolidated omnibus budget reconciliation act of 1985.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care

services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

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

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

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

6. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct ~~analysis~~ ANALYSES of genes or chromosomes.

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

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

(a) Health status.

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

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

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

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

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

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

coverage to individuals in the individual market is not a health care insurer that offers health insurance coverage in the individual market.

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

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

13. "Network plan" means a health care plan provided by a health care insurer under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers either under contract with a health care insurer licensed pursuant to chapter 4, article 3 of this title or under contract with a health care insurer in accordance with the determination made by the director pursuant to section 20-1053 regarding the geographic or service area in which a health care insurer may operate.

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

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

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

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

Sec. 12. Section 20-1402, Arizona Revised Statutes, is amended to read:

20-1402. Provisions of group disability policies; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Nothing in subsection B of this section:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

L. Any group disability policy that provides coverage for:

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

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

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

N. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 13. Title 20, chapter 6, article 5, Arizona Revised Statutes, is amended by adding section 20-1402.04, to read:

20-1402.04. Group disability policies; preexisting condition limitations or exclusions; prohibition; definitions

A. A POLICY ISSUED BY A GROUP DISABILITY INSURER SHALL NOT IMPOSE ANY PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY PREEXISTING CONDITION.

B. FOR THE PURPOSES OF THIS SECTION:

1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING CONDITION EXCLUSION.

2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS.

Sec. 14. Section 20-1404, Arizona Revised Statutes, is amended to read:

20-1404. Blanket disability insurance; definitions

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

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

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

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

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

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

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

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

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

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

service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

L. Nothing in subsection K of this section:

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

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

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

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

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

2. Involve amino acid, carbohydrate or fat metabolism.

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

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

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

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

U. Any blanket disability policy that provides coverage for:

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

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

V. Notwithstanding subsection U of this section, a religious employer whose religious tenets prohibit the use of prescribed contraceptive methods may require that the insurer provide a blanket disability policy without coverage for all United States food and drug administration approved contraceptive methods. A religious employer shall submit a written affidavit to the insurer stating that it is a religious employer. On receipt of the affidavit, the insurer shall issue to the religious employer a blanket disability policy that excludes coverage of prescription contraceptive methods. The insurer shall retain the affidavit for the duration of the blanket disability policy and any renewals of the policy. Before a policy is issued, every religious employer that invokes this exemption shall provide prospective insureds written notice that the religious employer refuses to cover all United States food and drug administration approved contraceptive methods for religious reasons. This subsection shall not exclude coverage for prescription contraceptive methods ordered by a health care provider with prescriptive authority for medical indications other than to prevent an unintended pregnancy. An insurer may require the insured to first pay for

the prescription and then submit a claim to the insurer along with evidence that the prescription is for a noncontraceptive purpose. An insurer may charge an administrative fee for handling these claims under this subsection. A religious employer shall not discriminate against an employee who independently chooses to obtain insurance coverage or prescriptions for contraceptives from another source.

W. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 15. Title 20, chapter 6, article 5, Arizona Revised Statutes, is amended by adding section 20-1404.04, to read:

20-1404.04. Blanket disability policies; preexisting condition limitations or exclusions; prohibition; definitions

A. A POLICY ISSUED BY A BLANKET DISABILITY INSURER SHALL NOT IMPOSE ANY PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY PREEXISTING CONDITION.

B. FOR THE PURPOSES OF THIS SECTION:

1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING CONDITION EXCLUSION.

2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH COVERAGE BENEFITS.

Sec. 16. Section 20-1408, Arizona Revised Statutes, is amended to read:

20-1408. Right to obtain individual policy; requirements; exceptions; definition

A. Each group disability insurance policy delivered or issued for delivery in this state shall provide for the right of all persons covered under the group contract to convert to an individual disability policy on the death of the named insured, the entry of a decree of dissolution of marriage or any other condition other than the failure of the insured to pay the required premium specifically stated in the policy under which coverage would otherwise terminate as to a covered spouse or covered dependent children of the named insured.

B. All persons exercising their right to an individual disability policy under subsection A OF THIS SECTION are entitled to have an individual disability policy issued to them by the issuer on a form provided for conversion which provides coverage most similar to that provided under the

group policy. Each person entitled to have a conversion policy issued to him may elect a lesser form of coverage.

C. A written application and the first premium payment for the converted policy shall be made to the insurer within thirty-one days following termination of coverage under the existing policy. A monthly premium rate shall be offered to the person exercising continuation or conversion rights, and payment of one monthly premium shall be deemed sufficient consideration to enact the continuation or conversion policy. The effective date of the conversion policy is the day following the termination of insurance under the group policy.

D. Coverage provided through the conversion policy shall be without additional evidence of insurability and shall not impose any preexisting condition limitations, exclusions or other contractual time limitations other than those remaining unexpired under the policy or contract from which conversion is exercised.

E. Conversion of coverage ~~may~~, at the option of the spouse exercising the right, MAY include covered dependent children for whom the spouse has responsibility for care or support.

F. The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

G. Each certificate of coverage shall include notice of the conversion privilege.

H. This section does not apply to disability income policies, to accidental death or dismemberment policies or to single term nonrenewable policies.

I. Conversion is not available to a person eligible for medicare or eligible for or covered by other similar disability benefits which together with the conversion coverage would constitute overinsurance.

J. At the time of filing a petition for dissolution of marriage, the clerk of the court shall provide to the petitioner for a dissolution of marriage two copies of the notice of the right of a dependent spouse to convert health insurance coverage under this section. The petitioner shall cause one copy of the notice to be served on the respondent together with a copy of the petition, summons and preliminary injunction. The director shall prepare the notice which must include a summary of this section. The clerk of the court or the director is not liable for damages arising from information contained in or omitted from the notices prepared or provided under this ~~section~~ SUBSECTION.

K. This section also applies to blanket accident and sickness insurance policies and to all disability insurance issued by hospital, medical, dental and optometric service corporations, health care services organizations and fraternal benefit societies.

L. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who had coverage under a disability insurance policy provided by the person's

employer at such time shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. Following reemployment by the reservist's former employer, the reservist shall make written application to the insurer within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of application by the insurer.

2. The coverage reinstated shall be the same coverage provided by the employer to other employees and their dependents in the employer group health insurance plan at the time of application.

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

M. Each dependent of a person eligible for reinstatement under SUBSECTION L OF this ~~provision~~ SECTION shall be afforded the same rights and be subject to the same conditions as the insured, if the dependent was insured under the disability insurance policy at the time the eligible person entered active duty. Any dependent of such person born during the period of active military duty shall have the same rights as other dependents noted in this ~~section~~ SUBSECTION.

N. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with the provisions of subsection L of this section, including:

1. Conditions of eligibility.

2. Coverage of dependents.

~~3. Preexisting conditions.~~

~~4.~~ 3. Termination of insurance.

~~5.~~ 4. Probationary periods.

~~6.~~ 5. Limitations.

~~7.~~ 6. Exceptions.

~~8.~~ 7. Reductions.

~~9.~~ 8. Elimination periods.

~~10.~~ 9. Requirements for replacement.

~~11.~~ 10. Any other conditions of group and blanket disability contracts.

O. A group policy or any conversion policy that is issued under this section shall not be cancelled or nonrenewed except if:

1. The individual has failed to pay premiums or contributions pursuant to the terms of the health insurance coverage or the insurer has not received premium payments in a timely manner.

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

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

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

5. In the case of an insurer who offers health coverage in the group market only through one or more bona fide associations, the membership of an employer in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor or any covered individual.

P. A conversion policy may be modified if the modification complies with the notice and disclosure requirements set forth in the group policy and evidence of coverage. A modification of a conversion policy which has already been issued to an insured shall not result in the effective elimination of any benefit originally included in the conversion policy.

Q. For the purposes of this section, "network plan" means a health care plan provided by an insurer under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers under contract with the insurer.

Sec. 17. Section 20-2301, Arizona Revised Statutes, is amended to read:

20-2301. Definitions; late enrollee coverage

A. In this chapter, unless the context otherwise requires:

1. "Accountable health plan" means an entity that offers, issues or otherwise provides a health benefits plan and THAT is approved by the director as an accountable health plan pursuant to section 20-2303.

2. "Affiliation period" means a period of two months, or three months for late enrollees, that under the terms of the health benefits plan offered by a health care services organization must expire before the health benefits plan becomes effective and in which the health care services organization is not required to provide health care services or benefits and cannot charge the participant or beneficiary a premium for any coverage during the period.

3. "Base premium rate" means, for each rating period, the lowest premium rate that could have been charged under a rating system by the accountable health plan to small employers for health benefits plans involving the same or similar coverage, family size and composition, and geographic area.

4. "Basic health benefit plan" means a plan that is developed by a committee established by the legislature and that is adopted by the director.

5. "Bona fide association" means, for a health benefits plan issued by an accountable health plan, an association that meets the requirements of section 20-2324.

6. "COBRA continuation provision" means:

(a) Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.

(b) Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code sections 1001 through 1461).

(c) Title XXII of the public health service act.

(d) Any similar provision of the law of this state or any other state.

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

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

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

(c) A health benefits plan issued by an accountable health plan as defined in this section.

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

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

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

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

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

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

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

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

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

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

8. "Demographic characteristics" means objective factors an insurer considers in determining premium rates. Demographic characteristics do not include health status-related factors, industry or duration of coverage since issue.

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

10. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analyses of genes or chromosomes.

11. "Health benefits plan" means a hospital and medical service corporation policy or certificate, a health care services organization contract, a group disability policy, a certificate of insurance of a group disability policy that is not issued in this state, a multiple employer welfare arrangement or any other arrangement under which health services or health benefits are provided to two or more individuals. Health benefits plan does not include the following:

(a) Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage or Taft-Hartley trusts.

(b) Coverage that is issued as a supplement to liability insurance.

(c) Medicare supplemental insurance.

(d) Workers' compensation insurance.

(e) Automobile medical payment insurance.

12. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in an accountable health plan, including:

(a) Health status.

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

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

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

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

13. "Higher level of coverage" means a health benefits plan offered by an accountable health plan for which the actuarial value of the benefits under the coverage is at least fifteen per cent more than the actuarial value of the health benefits plan offered by the accountable health plan as a lower level of coverage in this state but not more than one hundred twenty per cent of a policy form weighted average.

14. "Index rate" means, as to a rating period, the arithmetic average of the applicable base premium rate and the highest premium rate that could have been charged under a rating system by the accountable health plan to

small employers for a health benefits plan involving the same or similar coverage, family size and composition, and geographic area.

15. "Late enrollee" means an employee or dependent who requests enrollment in a health benefits plan after the initial enrollment period that is provided under the terms of the health benefits plan if the initial enrollment period is at least thirty-one days. An employee or dependent shall not be considered a late enrollee if:

(a) The person:

(i) At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefits plan.

(ii) Lost coverage under a public or private health insurance policy or any other health benefits plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.

(iii) Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a public or private health insurance or other health benefits plan.

(iv) Requests enrollment within thirty-one days after the date of marriage.

(b) The person is employed by an employer that offers multiple health benefits plans and the person elects a different plan during an open enrollment period.

(c) A court orders that coverage be provided for a spouse or minor child under a covered employee's health benefits plan and the person requests enrollment within thirty-one days after the court order is issued.

(d) The person becomes a dependent of a covered person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.

16. "Lower level of coverage" means a health benefits plan offered by an accountable health plan for which the actuarial value of the benefits under the health benefits plan is at least eighty-five per cent but not more than one hundred per cent of the policy form weighted average.

17. "Network plan" means a health benefits plan provided by an accountable health plan under which the financing and delivery of health benefits are provided, in whole or in part, through a defined set of providers under contract with the accountable health plan in accordance with the determination made by the director pursuant to section 20-1053 regarding the geographic or service area in which an accountable health plan may operate.

18. "Policy form weighted average" means the average actuarial value of the benefits provided by all health benefits plans issued by either the accountable health plan or, if the data are available, by all accountable

health plans in the group market in this state during the previous calendar year, weighted by the enrollment for all coverage forms.

19. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received ~~within not more than six months~~ before the date of the enrollment of the individual under a health benefits plan issued by an accountable health plan. A genetic condition is not a preexisting condition in the absence of a diagnosis of the condition related to the genetic information and shall not result in a preexisting condition limitation or preexisting condition exclusion.

20. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefits plan offered by an accountable health plan.

21. "Small employer" means an employer who employs at least two but not more than fifty eligible employees on a typical business day during any one calendar year. As used in this paragraph, "employee" shall include the employees of the employer and the individual proprietor or self-employed person if the employer is an individual proprietor or self-employed person.

22. "Taft-Hartley trust" means a jointly-managed trust, as allowed by 29 United States Code sections 141 through 187, that contains a plan of benefits for employees and that is negotiated in a collective bargaining agreement governing the wages, hours and working conditions of the employees, as allowed by 29 United States Code section 157.

23. "Waiting period" means the period that must pass before a potential participant or beneficiary in a health benefits plan offered by an accountable health plan is eligible to be covered for benefits as determined by the individual's employer.

B. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment is received within thirty-one days after the person becomes a dependent.

Sec. 18. Section 20-2304, Arizona Revised Statutes, is amended to read:

20-2304. Availability of insurance; premium tax exemption

A. As a condition of doing business in this state, each accountable health plan shall offer at least one health benefits plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The accountable health plan shall provide a health benefits plan to each small employer without regard to health status-related factors if the small employer agrees to make the premium payments and to satisfy any other reasonable provisions of the plan that are not inconsistent with this chapter.

B. If an accountable health plan offers more than one health benefits plan to small employers, the accountable health plan shall offer a choice of all health benefits plans that the accountable health plan offers to small

employers and shall accept any small employer that applies for any of those plans.

C. In addition to the requirements prescribed in section 20-2323, for any offering of any health benefits plan to a small employer, as part of the accountable health plan's solicitation and sales materials, an accountable health plan shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The accountable health plan shall provide information concerning the following:

1. Provisions of coverage relating to the following, if applicable:

(a) The accountable health plan's right to change premium rates and the factors that may affect changes in premium rates.

(b) Renewability of coverage.

~~(c) Any preexisting condition exclusion.~~

~~(d)~~ (c) Any affiliation period applied by a health care services organization.

~~(e)~~ (d) The geographic areas served by health care services organizations.

2. The benefits and premiums available under all health benefits plans for which the employer is qualified.

D. The accountable health plan shall describe the information required by subsection C of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefits plan. This requirement is satisfied if the accountable health plan provides each of the following for each product the accountable health plan offers:

1. An outline of coverage that describes the benefits in summary form.

2. The rate or rating schedule that applies to the product~~, preexisting condition exclusion~~ or affiliation period.

3. The minimum employer contribution and group participation rules that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

E. An accountable health plan is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

F. An accountable health plan that issues a health benefits plan through a network plan may limit the employers that may apply for any health benefits plan offered by the accountable health plan to those eligible individuals who live, work or reside in the service area for the network plan of the accountable health plan.

G. On approval of the director, an accountable health plan may refuse to enroll a qualified small employer in a health benefits plan or in a geographic area served by the plan if the accountable health plan

demonstrates that its financial or administrative capacity to serve previously enrolled groups and individuals would be impaired. An accountable health plan that refuses to enroll a qualified small employer may not enroll an employer of the same or larger size until the earlier of:

1. The date on which the director determines that the accountable health plan has the capacity to enroll a qualified small employer.

2. The date on which the accountable health plan enrolls a qualified small employer.

H. An accountable health plan that offers coverage to a qualified small employer shall offer coverage to all of the eligible employees of the qualified small employer and their eligible dependents.

I. An accountable health plan may request health screening and underwriting information on prospective enrollees to evaluate the risks associated with a qualified small employer who applies for coverage. The accountable health plan may use this information for the purposes of setting premiums, evaluating plan offerings and making reinsurance decisions. An accountable health plan shall not use this information to deny coverage to a qualified small employer or to an eligible employee or to an eligible dependent, except a late enrollee who attempts to enroll outside an open enrollment period.

J. Accountable health plans are exempt from the premium taxes that are required by section 20-224, subsection B and sections 20-837, 20-1010 and 20-1060 for the net premiums received for health benefits plans issued to small employers, including the net premiums collected from coverage issued pursuant to section 20-2313, subsection C. Each accountable health plan shall notify the small employers to whom it provides coverage of the reductions in the premium tax as specified in this subsection.

K. The director may use independent contractor examiners pursuant to sections 20-148 and 20-159 to review the higher level of coverage and lower level of coverage health benefits plans offered by an accountable health plan insurer in compliance with this section. All examination and examination related expenses shall be borne by the insurer and shall be paid by the insurance examiners' revolving fund pursuant to section 20-159.

Sec. 19. Section 20-2308, Arizona Revised Statutes, is amended to read:

20-2308. Portability

A newborn child, adopted child or child placed for adoption is an eligible individual if the child was timely enrolled and otherwise would have met the definition of an eligible individual as prescribed in section 20-1379 other than the required period of creditable coverage. ~~and~~ The child ~~is not~~ IS NOT subject to any preexisting condition exclusion or limitation. ~~if the child has been continuously covered under health insurance coverage or a health benefits plan offered by an accountable health plan since birth, adoption or placement for adoption.~~

Sec. 20. Section 20-2310, Arizona Revised Statutes, is amended to read:

20-2310. Discrimination prohibited; preexisting conditions; wellness programs

A. ~~Except as provided in subsection B of this section,~~ A health benefits plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability.

B. A health benefits plan shall not LIMIT OR exclude coverage for preexisting conditions. ~~, except that:~~

~~1. A health benefits plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under section 20-2308.~~

~~2. The accountable health plan shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.~~

C. A health benefits plan shall not include an affiliation period in a policy unless the affiliation period satisfies the requirements prescribed in 45 Code of Federal Regulations section 146.119(b).

D. On request of a health benefits plan, a person who provides coverage during a period of continuous coverage with respect to a covered individual shall promptly disclose the coverage provided to the covered individual, the period of the coverage and the benefits provided under the coverage.

E. The accountable health plan shall calculate creditable coverage according to the following rules:

1. The accountable health plan shall give an individual credit for each day the individual was covered by creditable coverage.

2. The accountable health plan shall not count a period of creditable coverage for an individual enrolled in a health benefits plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The accountable health plan shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period or an affiliation period for any health coverage.

4. The accountable health plan shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The accountable health plan shall not include in the determination of the period of continuous coverage described

in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer, is in a waiting period for benefits under a health benefits plan offered by an accountable health plan or is in an affiliation period.

~~5. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the accountable health plan shall count a period of creditable coverage without regard to the specific benefits covered during that period.~~

~~6. An accountable health plan shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth.~~

~~7. An accountable health plan shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.~~

F. An accountable health plan shall provide the certificate of creditable coverage described in subsection G of this section without charge for creditable coverage occurring after June 30, 1996 if the individual:

1. Ceases to be covered under a health benefits plan offered by an accountable health plan or otherwise becomes covered under a COBRA continuation provision. An individual who is covered by a health benefits plan that is offered by an accountable health plan, that is terminated or not renewed at the choice of the employer and where the replacement of the health benefits plan is without a break in coverage is not entitled to receive the certification prescribed in this paragraph but is instead entitled to receive the certifications prescribed in paragraphs 2 and 3 of this subsection.

2. Who was covered under a COBRA continuation provision ceases to be covered under the COBRA continuation provision.

3. Requests certification from the accountable health plan within twenty-four months after the coverage under a health benefits plan offered by an accountable health plan ceases.

G. The certificate of creditable coverage provided by an accountable health plan is a written certification of:

1. The period of creditable coverage of the individual under the accountable health plan and any applicable coverage under a COBRA continuation provision.

2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the accountable health plan.

H. Any accountable health plan that issues health benefits plans in this state, as applicable, shall issue and accept a written certificate of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer

providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

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

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

5. One of the following:

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

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

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

7. The consumer assistance telephone number for the department.

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

Important notice!

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

I. An accountable health plan may provide any certification pursuant to subsection F, paragraph 1 of this section at the same time the accountable health plan sends the notice required by the applicable COBRA continuation provision.

J. An accountable health plan has satisfied the certification requirement under this section if the accountable health plan offering the health benefits plan provides the prescribed certificate in accordance with this section within thirty days after the event that triggered the issuance of the certification.

~~K. If an accountable health plan imposes a waiting period for coverage of preexisting conditions, within a reasonable period of time after receiving an individual's proof of creditable coverage and not later than the date by~~

~~which the individual must select an insurance plan, the accountable health plan shall give the individual written disclosure of the accountable health plan's determination regarding any preexisting condition exclusion period that applies to that individual. The disclosure shall include all of the following information:~~

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

~~2. The basis for the accountable health plan's determination and the source and substance of any information on which the accountable health plan has relied.~~

~~3. A statement of any right the individual may have to present additional evidence of creditable coverage and to appeal the accountable health plan's determination, including an explanation of any procedures for submission and appeal.~~

~~L.~~ K. Periods of creditable coverage for an individual are established by presentation of the written certifications described in this section and section 20-1379. In addition to written certification of the period of creditable coverage as described in this section, individuals may establish creditable coverage through the presentation of documents or other means. In order to make a determination that is based on the relevant facts and circumstances of the amount of creditable coverage that an individual has, an accountable health plan shall take into account all information that the plan obtains or that is presented to the plan on behalf of the individual.

~~M.~~ L. The department may enforce and monitor the issuance and delivery of the notices and certificates by accountable health plans and insurers as required by this section, the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations adopted to implement the health insurance portability and accountability act of 1996.

~~N.~~ M. This section does not prohibit any health benefits plan from providing or offering to provide rewards or incentives under a wellness program that satisfies the requirements for an exception from the general prohibition against discrimination based on a health factor under the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 stat. 1936), including any federal regulations that are adopted pursuant to that act.

Sec. 21. Section 20-2321, Arizona Revised Statutes, is amended to read:

20-2321. Maternity benefits; adoption; coverage

A. A contract that is issued to an enrollee pursuant to this article and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of a child who is legally adopted by the enrollee if all of the following are true:

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

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

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

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

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

C. If other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent.

D. The enrollee adopting parents shall notify their accountable health plan of the existence and extent of the other coverage.

E. An accountable health plan is not required to pay any costs in excess of the amounts it would have been obligated to pay to its hospitals and providers if the natural mother and child had received the maternity and newborn care directly from or through that accountable health plan.

F. Beginning January 1, 1998, any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the accountable health plan for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The accountable health plan shall not:

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

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

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

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

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

G. Nothing in subsection F of this section:

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

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

3. Prevents an accountable health plan from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection F of this section.

H. An accountable health plan shall not impose any preexisting condition exclusions or limitations relating to pregnancy as a preexisting condition.

Sec. 22. Applicability

This act applies to contracts, policies and evidences of coverage issued or renewed from and after December 31, 2010.